P[illegible] Quarterly

OFFIC[illegible] OF THE NEW [illegible] STATE
[illegible] MENTAL HYGIE[illegible]

[illegible]

[illegible] Council

[illegible], M. D., *Editor*

[illegible], M. D., *Assistant Editor*

Associate Editors

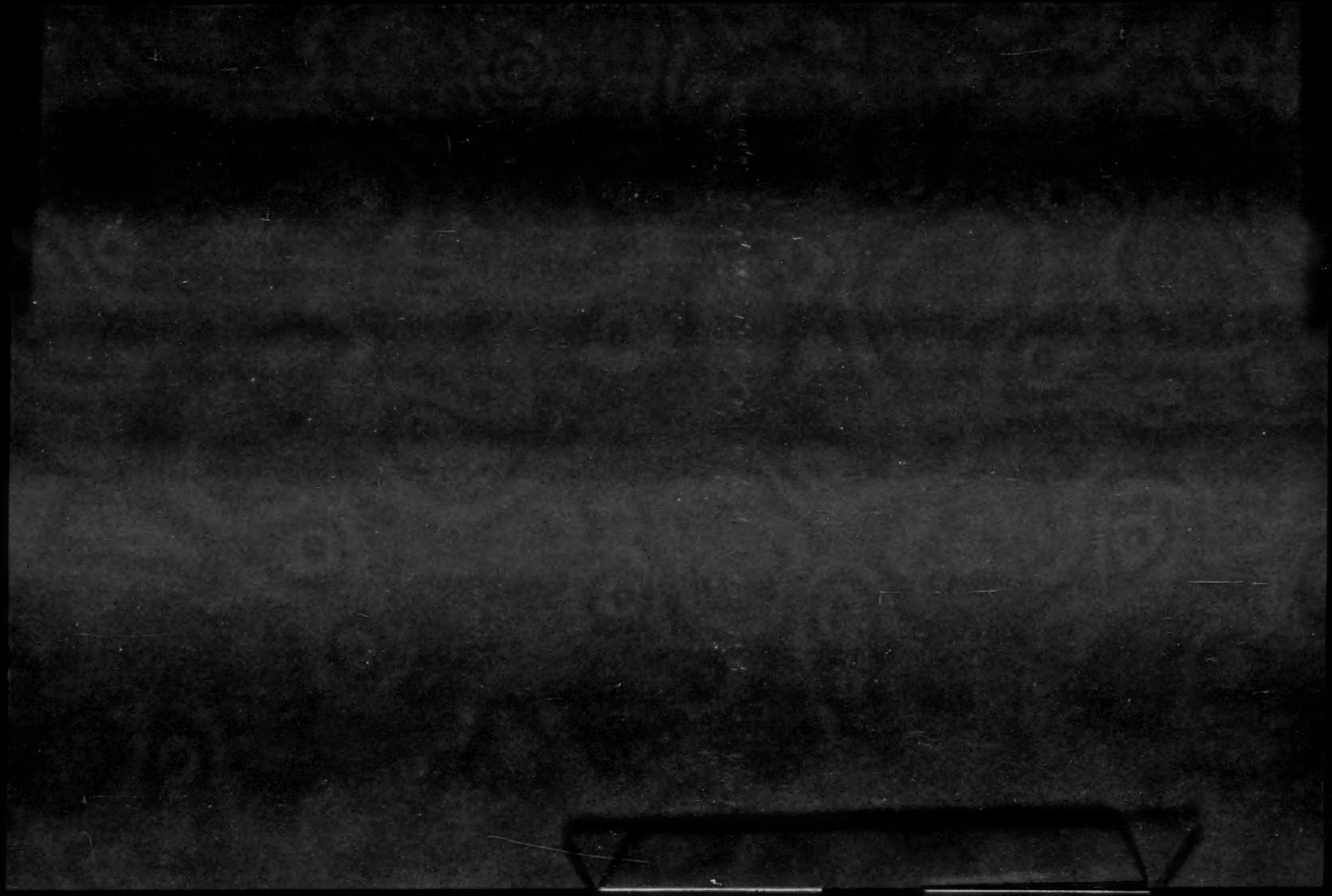
JAMES [illegible] ARCHIBALD [illegible], M. D.
ZYGMU[illegible] GEORGE [illegible], M. D.

[illegible], *Editor*
[illegible] WHITE, B. Lit.

[illegible]

[illegible] State Hospitals Press
[illegible], Utica, N. Y.

Vol. 2[illegible] [illegible] No. 3



The Psychoanalytic Review
A Quarterly Educational American Journal of Psychoanalysis
Devoted to an Understanding of Human Behavior
Founded in 1913 by
WM. A. WHITE, M. D., and S. E. JELLIFFE, M. D.
Managing Editor
NOLAN D. C. LEWIS, M. D.
Issued Quarterly: $8.00 per Volume; Single Numbers, $2.25
Outside Continental U. S. A., $8.80

THE PSYCHOANALYTIC REVIEW
70 Pine Street, New York 5, N. Y.

Vol. 25 JULY 1951 No. 3

THE PSYCHIATRIC QUARTERLY

PUBLISHED BY AUTHORITY OF THE
NEW YORK STATE DEPARTMENT OF MENTAL HYGIENE

---

*Dr. Whitehead is serving as editor of THE QUARTERLY following Dr. Bigelow's appointment as Commissioner of Mental Hygiene.

The Psychiatric Quarterly, formerly the State Hospital Quarterly, is the official organ of the New York State Department of Mental Hygiene.

Volumes begin with the January number. Individual subscription rate, $6.00 a year in U. S. and its possessions; $6.50 elsewhere.

Editorial communications, books for review and exchange should be addressed to the editor, Utica State Hospital, Utica 2, N. Y.

Business communications, remittances and subscriptions should be addressed to the State Hospitals Press, Utica 2, N. Y.

Entered as second-class matter April 17, 1917, at the postoffice at Utica, N. Y., under the Act of March 3, 1897.

MANUSCRIPTS

Contributions from any reliable source will be considered for publication. Manuscripts should be addressed to The Editor, PSYCHIATRIC QUARTERLY, Utica State Hospital, Utica 2, N. Y.

Manuscripts should be submitted in original (not carbon) copy, typewritten cleanly, double-spaced, with wide margins, typed on one side of the paper only. Paper should be light weight, bond finish, and opaque; onion skin should not be used. The author should keep a copy for convenience in editorial correspondence.

Short summaries to conclude all articles are requested. Contributors are asked to consult current issues of THE QUARTERLY for style of reference lists and bibliographies and to submit such lists in the form used by this journal.

A short, autobiographical note is requested from each contributor.

THE QUARTERLY makes a moderate allowance, without charge to the author, for illustrations and tabular matter. Authors may be asked to meet costs of such material in excess of this allowance. Authors may also be asked to meet costs of type-setting for any extensive changes made by them after an accepted paper is in proof. THE QUARTERLY supplies 25 free reprints for each article printed, with a varying additional allowance for papers with co-authors; further reprints may be ordered at a price schedule which is set to cover costs. Reprinting elsewhere for book publication or other purposes may be arranged by agreement with the editor.

Articles accepted by THE QUARTERLY are for first and exclusive publication unless otherwise agreed by specific arrangement with the editor. Co-publication or re-publication must be arranged with the editor before publication in THE QUARTERLY.

DIFFERENTIAL PSYCHOTHERAPY OF BORDERLINE STATES*

BY VICTOR W. EISENSTEIN, M. D.

I

The borderline category of so-called narcissistic neuroses presents not merely the challenge of differential diagnosis, but the practical problem of differential treatment. Superficially, patients of this type appear to function at a neurotic level. They hold jobs or attend school, enjoy musical or artistic interests, socialize, engage in sexual relations, yet suffer from deficient emotional contact and from a seriously impaired sense of reality. Clinically, they complain of varying degrees of boredom, depression or free anxiety and present abortive paranoid features, transient feelings of reference or depersonalization—often with acute exacerbations —that are dynamically rooted in serious psychopathology. Hoch and Polatin[1] presented illustrative cases of the type under discussion in a recent contribution aptly entitled "Pseudoneurotic Forms of Schizophrenia." The improper evaluation of such patients at the start frequently leads to misdirected therapy.

The incidence of borderline syndromes encountered varies with the setting and the type of individual practice. In private psychiatric practice and agency experience,** the writer found that 30 per cent of 250 consecutive consultations were, by clinical standards, such borderline reaction types; while in the psychiatric outpatient department of a general hospital (Lenox Hill) he found only 15 per cent of 100 cases. Piotrowski and Lewis[2] recently reported that almost 50 per cent (20 of 41 patients) who had been discharged from the New York State Psychiatric Institute with a diagnosis of *psychoneurosis* developed definite signs of schizophrenia in the interval between discharge and the follow-up some years later. Corroboration is also to be found in the Rorschach records that show an admixture of neurotic and psychotic mechanisms. In a random sampling of 50 Rorschach psychodiagnostic referrals of private adult patients, Woltmann[3] found that 32 per cent fall into the borderline category by test criteria.

Many therapeutic failures of classical psychoanalysis belong in

*Presented at the 107th meeting of the American Psychiatric Association, Cincinnati, Ohio, May 9, 1951.

**The Consultation Center, Jewish Family Service, New York, N. Y., and the Family Consultation Service, Eastchester Neighborhood Association, Tuckahoe, N. Y.

this group.[4] In view of the major contribution of psychoanalysis to dynamic understanding of borderline neuroses, this fact may appear paradoxical. However, the paradox lies in the fact that techniques of therapy in general application have not kept pace with the theoretical understanding of these disorders. To treat borderline states as "transference neuroses" is an error fraught not only with disappointment, but with the danger of precipitating psychotic episodes. Federn[5] cautioned in this regard: "The most important self-defense against schizophrenia is the neurosis, which is usually of the hysterical or obsessional type. *No latent schizophrenic should be 'cured' of his neurosis, and he definitely should not be treated by the standard form of psychoanalysis.*"

Various technical considerations involved in the intensive psychotherapy of borderline states have been the subject of recent articles, notably those of Stern,[6] Federn,[5] Schmideberg,[7] and, more recently, Fromm-Reichmann.[8] These authors agree on several cardinal principles which have been evolved for the treatment of borderline states: (1) the need for a strong human and supportive attitude on the part of the therapist, (2) avoidance of "free-association" techniques of classical analysis, and (3) preference for the sitting position for the patient. Their experience has shown that the establishment of emotional contact from the start is far more effective for the attainment of clinical improvement than is the production of material.

This paper aims to outline a comprehensive plan of treatment, suitable in such cases, and to present certain specific procedures appropriate to each phase of psychotherapy. Since these are departures from the methods used with psychoneurotic patients on the one hand and with deteriorated schizophrenics on the other, the differential handling and reasons therefor will be discussed. While the plan of treatment is psychoanalytically oriented, the technical procedures outlined are, to a large extent, utilizable by psychiatrists of diverse theoretical orientations.

Since the premises on which a plan of treatment is based determine the nature of the therapist's relationship to the patient, the nature of the interpretations and the goals of treatment, these will be briefly stated. The *major* premise, as determined by psychoanalytic investigation[9] is that the ego or integrating apparatus of the borderline patient is itself severely involved; and that this affects his reality testing, personal relationships, emotional reac-

tions and integration, and the manner of handling unconscious conflicts. This serious psychic involvement is expressed in a personality that goes about the daily business of living, but to a greater or lesser degree denies, projects or misinterprets the psychic tensions arising out of the conflict between the demands of reality on the one hand and the clamorous infantile needs on the other. Matters can be started aright therapeutically only if emotional contact is somehow established with the patient's residual healthy portion and we help him to become interested in how and why he protects himself by one or another type of withdrawal from reality.

The *minor* premise, as engraved in the therapist's attitude, is that he is dealing with a person who, in spite of relatively normal function and manifestly neurotic appearance, is suffering from the scars of early and very deep narcissistic wounds. Genetically considered, such patients have been traumatized in the earliest stages of their lives at a time when almost without exception "mother is all." These people are crushed in their basic self-esteem, and are reactively self-centered and omnipotent in their feelings. They are primitive in their emotional reactions and bristling toward their environment. Moreover, they are inwardly pre-verbal children with a predilection for acting rather than speaking; they poorly differentiate fact from fantasy, and are moved by a primitive sense of the magical. They are ambivalent at best, affect-hungry, masochistically deformed, superlatively sensitive to implied slights or rejections, and ever ready to react by shrinking or running away from anticipated reproach, frustration or temptation implied in any close relationship.

When they come to treatment, emotional contact with the therapist is, therefore, as much feared as sought. Such patients are made anxious by aloofness of manner; yet tend to be suspicious of warmth. If they feel negative or anxious, they are apt not to show up for the next interview, being too frightened even to telephone to cancel it. The therapeutic approach in such cases is necessarily focused on the treatment of the weak and narcissistic ego structure.[10] In these disorders, the therapist must, therefore, assume the active and benevolent role of a parent, rather than the customary neutral position of an impersonal analyst; yet he must provide more than supportive or educational help, if the patient's inner situation is to be changed.

The treatment of borderline cases may be considered in three phases: (1) the initial phase of establishing affective contact, (2) the actual psychotherapeutic working alliance, and (3) the period of weaning and adjustment. Each phase presents its own set of technical problems and each calls for a specific therapeutic attitude.

II

The First Phase of Treatment

Unlike the true psychoneurotic patient, the borderline patient does not, as a rule, have sufficiently good emotional contact at the start to join in the therapeutic endeavor aimed at producing inner change. A preliminary period, oriented toward the establishment of contact through discussion of the patient's current problems, with active support from the therapist, is invariably required. By and large, the life situation of most of these patients is not good. Strife within the family is a common situation. The patient seeking advice and help with family problems is also seeking the therapist's alignment with him. In view of the adverse situations which really exist, and generally of the psychopathology existing in other members of the family, one has to be prepared with this type of patient literally to become the "family psychiatrist."

It holds true with these milder borderline cases, as with the seriously ill schizophrenic patients described by Federn,[5] that they have, unconsciously, a strong oral orientation in their relationships. To them, literally, actions speak louder than words. Therefore, the generally giving attitude on the part of the therapist has its psychotherapeutic rationale (a hand-shake, a cigarette, a cool drink, etc.). Contrarily, the attitude of tolerant, skeptical inquiry and the frustration of gratifications, so suitable in the transference neuroses, engenders greater anxiety and defensiveness in these patients. A certain amount of easy informality and talkativeness on the part of the psychiatrist, as emphasized by Schmideberg,[7] is, in essence, part of the attitude of friendly understanding which such patients must sense with a psychiatrist. The natural conversational manner literally demonstrates acceptance; and warmth of approach is not just an act of kindness, but a technical necessity in such cases. If actual support with external problems cannot conveniently be given by the psychiatrist himself, this can be arranged in collaboration with a trained psychiatric case worker. Occasion-

ally, the help of the family doctor can be mobilized in such cases, particularly where the latter has had a good and prolonged relationship with the patient's relatives.

These considerations are preliminaries to actual treatment, yet neglect of details often spells the difference between success and failure in establishing treatment contact. The degree of rapport engendered in discussions of the current situation necessarily leads to the patient's reasons for his treatment, his reluctance, and his working out of arrangements for the treatment.

FREQUENCY OF INTERVIEWS

Given an arrangement of three sessions a week for an office patient, what is the most advantageous spacing? With the true psychoneurotic patient who is limited to three sessions, it is usually advantageous to have these on successive days to facilitate the continuous flow of material, to accelerate the establishment and observation of the transference relationship, and to afford a continuous opportunity for working through the material which appears. In the borderline group, however, the preference, based on the author's experience, is for a spacing of interviews on alternate days. This procedure presents several advantages. It not only reduces the possibility of enforced dependency, but diminishes the tendency toward disappointment reactions inherent in such attachments. The day between sessions also serves for working through transference and other feelings that are mobilized and allows for the assimilation of interpretations.

One may note here, incidentally, that because these patients are extremely sensitive to change, the therapist should adhere as closely as possible to the schedule originally worked out for the patient. In more cases than not, a change of hour is felt as a rejection, and subsequent treatment-contact suffers. Moreover, one should state early in the contact that the psychiatrist is available for telephone calls at certain hours, should anything disturbing arise. This is an important practical consideration, because the low tolerance for anxiety of many of these cases would make for "acting-out" that would be inimical to the patient's progress. A given type of "acting-out" may take the form of flight to another city, leaving school or job, the breaking up of marriage, impulsive actions of anti-social nature, or even suicide.

INITIAL NEGATIVE ATTITUDES

Since the diagnosis of borderline state carries the certainty that one is dealing with a highly-ambivalent person, reduction of negative feelings becomes the first item on the therapeutic agenda. The more consistently that attitudes of fear, distrust, disappointment, or resentment with previous therapists and related figures are ventilated at the start, the greater the probability that the patient will be brought into a more trusting and favorable relationship, and the greater the emotional contact that ensues. The initial handling of the patient's negative attitudes of distrust or resentment is a prerequisite for therapeutic effort, no matter what the theoretical orientation of the psychiatrist may be.

An apprehensive, or suspicious, attitude toward treatment is handled in the borderline patient quite differently from the way it would be in an ordinary neurotic patient. For example, if a patient asks, "Is that a dictaphone on your desk?" or "Is that machine taking down what I say?" one would ask a psychoneurotic patient, "What does the idea of my taking down your remarks bring into your mind?" and so, through free-association, perhaps arrive at the defense against some derivative of an unconscious infantile wish which is then worked through to its deeper levels. In the borderline patient, however, one simply answers, "No, it is not in operation. Why would you think I would want to record what you are saying?" The suspicion is then further countered by inviting the patient to see how the machine actually works and to test the reality for himself. The focus of treatment here is on the improvement of reality-testing functions of the patient's ego, not on the stirring up of paranoidal fears in the interest of obtaining "material."

Other attitudes of resistance are generally handled as in psychoneurotic cases, but with more reassurance from the therapist. The use of the word "resistance" connotes to the borderline patient an accusation of stubbornness, hence is to be avoided. On the other hand, the demonstration of a hidden fear in such defensive developments as drawing back the chair from the desk, silence, an averted gaze, or a tense bodily position, is apt to be accepted. The manner in which such inquiries are made is more important in these cases than the words used by the therapist.

In the analysis of an ordinary neurotic patient, such matters as tardiness or missed appointments are invariably taken up when

they appear. The borderline patient, however, is very likely to feel that the calling of lateness to his attention constitutes disapproval. Ordinary neurotic patients do not need to be convinced of the presence of a resistance if they have taken a train in the wrong direction in coming to treatment, or have gotten off at the wrong station. The borderline patient is better asked casually, "Did something interfere with your coming?" or "Does something hold you back when you feel like coming here?" The fear of disapproval or apprehension about being deceived, or the implication of temptation, as the case may be, must be brought into the discussion of these early attitudes toward treatment.

Among the negative attitudes, it may be relevant to mention questions regarding the sitting position. Nowadays, it is not uncommon for the informed patient to inquire why he is not lying down on the couch when the assumption is that he is coming for the treatment of a psychoneurosis. If the therapist indicates, "I feel that we can more conveniently talk over your real problems in this way," he points up with vividness the therapist's role and his interest in reality. If a declared wish to lie down is repeated and no special indication for it exists, this may be interpreted as an attempt at withdrawal from direct visual contact, out of a particular fear that should be discussed.

INITIAL ACTIVITY IN APPROACH

One may characterize the approach to the borderline patient as "active." This activity refers to initiative in, and direction of, interviews, and is not to be confused with the type of activity used by some therapists in making direct interpretations of psychotic content (ordinarily unconscious content) for the purpose of establishing contact with uncommunicative or deteriorated schizophrenic patients.[11] Rather, the preliminary activity refers here to a discussion of the patient's reality and his reasons for wanting to escape it.

For example, in a highly anxious type of borderline patient, presenting travel phobias or tormenting obsessive fears of hurting one's children as the chief concern, it is mandatory to reduce the underlying guilt early, in order to reduce the extreme agitation. The initial inquiry, then, stems from the question, "Against whom is the illness really being directed?" This generally involves the husband or wife, and the expression of grievances in the current

marital relationship soon affords the possibility of inquiring, "When did you feel like that before?" This not only reduces guilt, but fosters a therapeutic working arrangement in linking the difficulty with the past. An explanatory statement, followed by questions, directs the interview in these cases, where free association is neither desirable nor effective; and questions have a further value in moderating the amount of anxiety, shame or guilt evoked in any one session.

The transition from the first phase of treatment to the therapeutic relationship can also be made at a time when the patient expresses a request for help at a time of indecision. Where sufficient material has been obtained about the developmental history, such requests for advice are used in a manner that links them up to the patient's past.

Thus, an anxious patient, presenting fears of suicide, one day asked impulsively, "Do you think I ought to annul my marriage? I can't stand my husband sleeping near me!" It was suggested: "If at this time, instead of dissolving your marriage, we could discuss your present and previous sleeping arrangements, we might help you find out *why* you want to withdraw." She then reluctantly narrated her feelings of embarrassment and resentment toward her parents at having to share a bedroom with her brother continuously from early childhood to the time of her marriage. The favored position of her brother in her parents' estimation followed; and her guilt-laden hostility to the brother, whom she also admired, occupied the discussions for a long time. Thus, the burden of self-destructive guilt which she had first presented began to be reduced.

These directed, early interviews, based on the therapist's estimate of the present difficulties, avoid situations of anxious silences which are very likely to occur in such cases, and open the way for interpretive psychotherapy.

III

The Second Phase: The Actual Therapeutic Working Alliance

Psychotherapy, through the medium of discussion rather than free association, is made feasible after the first stage. The focus of the therapist is on the actual weak ego-state of the patient and on measures to improve its strength, rather than on material for interpretation. Reduction of the patient's guilt and anxiety is one

of these resources; raising the self-esteem through the commendation of some actual accomplishment of the patient is another desirable feature; but what is therapeutically decisive is interpretation of the patient's adaptive difficulties and their origins in his history. In connection with cases of this kind, Fenichel[9] states: "The narcistic regression is a reaction to narcistic injuries; if they are shown this fact and given time to face the real injuries and to develop other types of reactions, they may be helped enormously."

Since the working through of current emotional attitudes in relation to many previous experiences is the main occupation with the borderline, as with any psychoneurotic, patient, only differences in method, or in emphasis will be considered here. Early ambivalent, or hostile identifications predominate in the make-up of such borderline individuals, and these must be adequately demonstrated if the patient is to understand the early origin and true direction of his resentment. The material for such demonstration is always at hand in the pre-verbal communications of the patient —a facial tic, or a gesture such as putting the fist in the mouth, tearing at his nails, clenching his teeth, biting his lip, etc. Such bodily attitudes, when tactfully inquired into, and judiciously handled, mobilize the affect involved in this bit of dissociated behavior, and, when successful, show the patient that all is not forgotten, even from the time of life when he could not yet speak.

The therapeutic utilization of the pre-verbal portion of the ego helps the patient put his feelings into words instead of actions (i. e., reduces the tendency to acting). Certain defensive bodily attitudes can be safely demonstrated to the patient and his curiosity engaged regarding their meaning and function. (On the contrary, obvious erotic gestures, finger-play, repetitive rhythmic movements, or turning a chair one way or the other toward the therapist, if brought to the patient's attention, only embarrass him and evoke his further defensiveness.) The patient's use of stereotyped phrases, such as "maybe," "I think," or "I don't know," or similar mannerisms of speech, indicating an underlying indecisiveness or ambivalence, may be demonstrated in relation to his underlying fears of aggressiveness. Facial expression, or the lack of it, may also interest the patient from the standpoint of understanding its cause. In many borderline cases, lack of facial expression more often reflects an actual lack of contact than it does the repression of feelings; calling attention to this lack often succeeds

in thawing out frozen affects. The patient should not feel ridiculed or mocked, lest he carry his defensive withdrawal further. Properly handled, however, such procedures as duplicating the patient's expressions or movements, may help the patient realize his defensiveness and may engage his interest in underlying attitudes, —i. e., in *how* he says something, rather than what he says.

It may be relevant at this point to indicate the essential, yet subsidiary, role of early memories in the discussion of the patient's present reactions and attitudes. This can be illustrated in the following:

An extremely anxious patient, given to violent actions, who appeared "hysterical," but whose history was marked by a definite acute schizophrenic episode, recalls as her first memory (at two and one-half years) a situation of abandonment: "I was on the porch crying. My mother watched from a distance, but didn't come over."

In the therapeutic discussion of this patient's bodily attitudes, this memory frequently served as a focal point and was referred to in relation to such factors as her clinging to a bus seat, somehow unable to leave it; her fears on leaving the psychiatrist's office at the end of the hour; her expressed craving to be touched; her banging of her head against the wall in a previous therapist's office at the moment when she wished to be touched; and her cringing, jerking movements which expressed denial of the wish, out of the fear of its frustration. Thus, this memory became the symbol of the coexisting early ego state which caused her to attempt to reproduce in the present reality the traumatic early masochistic relationship.

In the ordinary psychoneuroses, where free-associative material is abundant, the first memory is ordinarily of no great therapeutic importance. In borderline cases, however, this first conscious remembrance[12] provides a springboard for fruitful discussions of early feelings and relationships which can and should be tied up by the psychiatrist at the appropriate times, with current feelings and with the actual doctor-patient relationship.

IV

Interpretation of Emotionally-Charged Content

Interpretation of deeper, emotionally-charged and ordinarily unconscious material, is limited by the precarious state of integration in borderline patients. The specific material, presented with

this limitation in mind, refers to (1) dreams and fantasies, (2) hostility and ambivalence, (3) homosexual material, (4) acting out, and (5) suicidal impulses. These are probably the most frequent situations where the technical handling may spell the difference between precipitating or avoiding panic, or an acute psychotic episode. The aim in latent schizophrenic cases, as has been emphasized by Federn,[5] is not "to make the unconscious conscious," but to foster re-repression of erupted unconscious emotions and fantasies through improvement in reality testing. As a general rule, in borderline cases, limited interpretations are the best psychotherapy.

DREAMS

Stern[6] points out how borderline patients tend to bring dreams as a sort of mute plea for help or approval, depending on the relationship with the therapist. In many such cases, there is a tendency for the patient who is somewhat familiar with the relationship of dreams to psychoanalysis, to bring in dreams in isolation, as it were, saying almost: "Here, analyze this." It is a vicarious sacrifice, and frequently is diversionary, from the fear of having one's deeper feelings known. When such a patient brings a dream, it is often helpful to ask: "Why did you dream that?" or "What do you understand about it?" Attempts at analysis beyond this point are better postponed to later stages. There is much less personal responsibility for dreams than for current reality material, therefore the patient is often not reluctant to bring in such material; or his interest in fantasy may actually be greater than in reality. Allowing for the misuse of dreams, snatched from the clouds, as it were, and brought into therapeutic sessions, there is an advantageous use of dreams in these cases: i. e., they are invariably useful for demonstrating hidden negative attitudes toward the treatment and, too, they must invariably be linked up with the known problems under discussion.

In suitable cases, post-coital or post-masturbatory dreams may be used selectively, only for pointing out guilt or anxiety regarding sexual matters.[13] Repetitive dreams of the past, which have been narrated by the patient, particularly those where he has been the target for aggression or punishment, are often useful in linking the connection to the patient's fears in therapy. Very frequently, dreams of self-destruction appear in this category of patients. If

discussed from the self-punishment aspect, dangerous acting-out may be prevented.

Finally, and particularly in the more serious cases, the reality situation is often more accurately perceived by the patient in his dreams than in his waking state. Freud notes, for example, certain cases of schizophrenia in which the delusion was corrected by a dream.[14] One such patient, in the present author's experience, isolated in dreams the portion of the ego split off from reality. That portion frequently appeared in the dream as a hostile "trouble-maker" who was bent on destroying himself and everybody else, while the other portion in the dream expressed horror, shouted denials, or was aligned against the "trouble-maker" portion. However, the integration of such insights with the patient's affective life and waking behavior is not effective until a trustful working relationship with the therapist really exists.

CONSCIOUS FANTASIES

If the focus of treatment remains, as it should, on the patient's reality adjustment, one shows a minimum of interest in his fantasies and a maximum of interest in his life situation, from which the fantasy is a withdrawal.

An example will be suitable to illustrate. Some years ago a woman who appeared "neurotic" in most particulars, but who was actually borderline psychotic, came in one day to report a fantasy in which she rode into the woods on a horse, dismounted and put on a rubber penis, then had intercourse with another girl. She talked on, of homosexual elements, and this release only alarmed her to the point of panic. The massive anxiety evoked by her discussion was expressed in a diarrhea which lasted for many weeks afterward.

Now, assuming that this material had been brought in by an ordinary psychoneurotic patient, who had been prepared for the affects by a preliminary working through of her anxieties, the ventilation of such a fantasy would have had a further cathartic effect and could have been integrated through the patient's further free associations. On the other hand, in a frankly psychotic patient, such a fantasy could be temporarily accepted as legal tender of the patient's psychotic reality. ("What do you want with the penis?); i. e., the therapist becomes, as it were, temporarily the delusional partner of the patient. In borderline patients, however,

the fantasy is best utilized for the verbalization of the patient's *discontent* with the reality of her femininity. For example, the patient could be asked: "What made you so dissatisfied with being a girl?" This would not only stem the flow of homosexual anxieties, but would lead to genetic elements that would help the patient see and feel the reason for her withdrawal into such fantasies.

Incestuous dreams and fantasies may be brought in by the patient, often without any open show of concern on his or her part. The aim of integration is not furthered by a release of deep feelings connected with these fantasies; in fact, greater anxiety and withdrawal may ensue. Undue interest of the therapist in the Oedipus complex as such, invites more and more fantasy life, which should be avoided until there is sufficiently healthy attitude to cope with the affects and with the true perspective of the material.

HOSTILITY AND AMBIVALENCE

The borderline patient's capacity to love has been crippled by ambivalent conflicts in his earliest years. Hostility in these cases is not a matter of defusion of instincts, as in the severely destructive, frankly psychotic patient. Once the guilt has been appreciated, what has to be identified in the borderline patient is the struggle of hostility and dependency attitudes. Hostility can often be interpreted along the lines that the patient hates certain people because he really fears them—fears that they can hurt his pride, or dominate him, or ignore him, or even take advantage of him. Discussions of hostility in regard to parents may generate too much guilt if related too early, or if a degree of realistic financial or other dependency exists simultaneously.

For this reason, it is preferable to focus on current authorities, employers, teachers, etc. When, as frequently happens, the borderline patient verbalizes his frank murder fantasies, the realistic expectations can be discussed in a matter-of-fact way, then linked with the question: "What caused you to feel so furious before this?" Since the patient usually fears his hostile impulses, however glibly they are expressed, some discussion of these as "frightening thoughts" may be required. The working through to the primary situation in which the hostility is rooted is contingent upon the establishment of good transference relationship in which such analysis is possible. Other aspects of hos-

tility, which is the greatest obstacle to progress in borderline states, will be more fully considered in the section on transference.

HOMOSEXUAL MATERIAL AND MASOCHISM

Material in regard to homosexuality is usually brought up out of a fear component. One type of reassurance is almost invariably called for in these cases, the pointing out of the realistic difference between the *fear* of being a homosexual and the actuality of being one. Failure to observe this precaution may sometimes precipitate a panic reaction or a florid paranoid state. The flight from the danger of homosexual temptation implied in the therapeutic relationship will be discussed in connection with transference reactions. Similar considerations apply to attitudes of masochism which are usually strongly developed in borderline patients.

One way in which a narcissistically-wounded ego attempts to protect itself is by masochistic deformation. The masochistic attitude of submission, or dependency interspersed with rebellious defiance, is something of a chronic atonement for feelings of guilt over hostile impulses that originated toward early "love objects." In treatment, one can demonstrate the atonement tendencies. The erotic gratification implied in the situation is best deferred. It is more advantageously demonstrated as a protection in dealing with those whom the patient considers more powerful than himself (or even omnipotent). It is, perhaps, relevant in this connection to mention that this is one of the reasons why lying down is contraindicated in these patients. For the patient to be on the couch during the interviews, only accentuates the masochistic and dependent attitudes and exaggerates the doctor's fantasied (projected) omnipotence in the patient's mind. The result is that the therapist is not seen or felt as the representative of reality that he should be.

ACTING-OUT

Fenichel[15] has pointed out that in patients regressed to, or fixated at, the pre-verbal infantile level, "acting-out" serves as a reassurance against a fantasied danger, a denial of that danger, or an escape from it. Whether in the ordinary psychoneurotic patient, or in the borderline patient, nothing short of accurate affective interpretation linked with specific episodes in the past will entirely eliminate tendencies toward acting-out, i. e., running away

from the treatment, leaving town, joining the army, certain types of sexual promiscuity, etc. These tendencies can be most effectively handled through showing the patient how he tends to cope with the inner "danger" situations. In borderline states, where the ego is weak, and the impulsions are strong, it is most often necessary to reinforce these interpretations with some reassurance or advice on the inadvisability of this or that course of action which would be damaging to the patient.

Schmideberg[7] points out in regard to her experience with the "psychopathic" variety of borderline patients that the only means of preventing them from getting into difficulty is to lessen the pressure on them by a combination of positive transference, interpretation, reassurance, advice, and improvement of the environmental situation. Since these patients, realistically, must be protected against their impulses on occasions, the therapist's working relationship with other members of the family is a matter of paramount practical importance. (Rarely in the actual treatment of true psychoneurotic adult patients, does it become necessary for the therapist to contact other members of the family.)

SUICIDE

The danger of suicide is an ever-present one with a large percentage of borderline patients. It is discussed in relation to unconscious or deeply emotionally-charged material, since the suicidal impulsion is often connected with these factors. Suicidal impulsions are especially prone to occur at the point where the patient feels that difficult "demands" are being made on him for change; and this should be pointed out, if the patient fears that he is not progressing or satisfying the doctor's or relatives' assumed demands. Interpretation of the underlying guilt and hostility is invariably necessary, i. e., "What has caused you to be so extremely angry at them and at yourself?" or "Who would suffer if you did do away with yourself?"

Pointing out the fear of abandonment by the therapist or the patient's giving up the hope of ever being loved (as related to developmental material) is often relevant. The working through of hostile identifications on a long-term basis, reduces the self-destructive drive, and is useful in an emergency only when it has already been the topic of previous discussions. Obviously, a positive transference, or what there is of it, is the best resource at

the command of the therapist in this connection, for, on the basis of this alone, he may consider with the patient, the postponement of any life-or-death solution until the psychotherapy has had a trial at alleviating the present desperate feelings. It goes without saying that the psychiatrist, in making himself available to patients by telephone on an emergency basis, as indicated in the first section of this paper, has reinforced libidinal ties that would reduce self-destructive possibilities.

V

Transference and Counter-Transference

The quality of a relationship with a borderline patient might be designated as tangential contact. The aim of treatment is to merge these areas of tangential contact into a more cohesive and less regressive transference. Identifications necessarily play a large part in the therapeutic relationships of such patients, since the subject and object boundaries are not sharply delimited in the early ego states which they present. Though less reliable than in the ordinary psychoneuroses, their transference reactions are more intense and may reach passionately childish levels of expression in either hostile or erotic phases. One may expect more unpredictable reactions than in ordinary psychoneurotic patients. The mute bid for approval and love is ever present and ever ready to be disappointed; withholding a word of approval in these cases is technically indefensible. The frank dependent and masochistic needs are easily thwarted, and running away from treatment without serving notice is a common occurrence, as emphasized by Stern.[6] In view of what has been stated regarding the traumatic ego warp in these cases, the therapist expects the patient to react like a hurt child coming to mother with his grievances. This pre-Oedipal type of transference should therefore be nurtured, not interpreted, until the treatment is very well advanced.

Nevertheless, what aspects of the transference should be brought to the patient's attention? Without an analysis of transference, the patient can have no emotional conviction of the misreading of the past into his or her present situation. Positive transference is all to the good in offsetting the strong egocentric preoccupation existing in such cases; yet the regressive aspects must be interpreted. Analyzing the thwart-reaction to dependency upon the omnipotently fancied therapist may bring the relationship to a more real-

istic level. Similarly, when the dependent attitude is an overcompensation for sadism, the guilt connected with the latter may be brought out in order to reduce the patient's need for "protection" from the therapist. Since regression may be activated by erotic temptations implied in the treatment setting, such sexual or homosexual anxieties when they interfere with the treatment can best be countered by inquiry into the fear rather than pointing up any positive manifestations.

The patient's intense hostility is a great obstacle to progress, and his fear of therapeutic retaliation must be brought out. Flescher[16] has pointed out that the latent psychotic patient's destructive feelings and fears are "probably responsible for more of his social withdrawal than is the narcistic position of his libido." Fear of one's aggressive impulses may make for difficulty in treatment, or may lead to the interruption of treatment until the patient masters his fear of his mounting hidden aggression toward the therapist.

Because of the early masochistic deformation existing as an adaptation to early relationships, the transference reactions of borderline patients are apt to be dominated by masochistic attitudes. Commonly, the patient tries to maneuver the therapist into the position of refusing, i. e., into the image of the mother refusing food and love to the child. Interpretation of the wish to be refused, as outlined by Bergler[17] is often a helpful expedient, particularly with borderline patients (who constitute many of the so-called "oral" types).

The element of narcissistic identification with the therapist plays a considerable role in such cases, and it is a question calling for considerable discretion at what point to call this to the patient's attention. So long as the manifestations are relatively innocuous, nothing need be said. However, when patients endanger their personal relationships by indulging in gratuitous "analyses" of their friends, the identification should be pointed out for its real danger, rather than on the basis of competition or of gratifying libidinal desires.

With few exceptions, it may be said that the analysis of negative attitudes, disappointment, distrust, resentment, etc., engenders in practice less of a tendency to regression and relapse in general than does the exposure of hidden erotic attitudes.

The major resistances encountered in an ordinary transference neurotic serve to ward off repressed libidinal feelings; the major resistances encountered in a borderline patient are due to fears of aggressive feelings. In the classical analysis of neurotic patients, an attempt is usually made to avoid resistances that drain interest from the transference situation to outside activities; in the borderline patients, on the contrary, one promotes the drainage of interest to partial sublimations, hobbies and social endeavors, as far as possible. The whole orientation, unlike that in transference neuroses, is to keep the patient as far as possible in a favorable and trusting state of transference toward the therapist. Under the influence of this relationship, some egocentric interest is directed into reality-oriented channels.

COUNTER-TRANSFERENCE PROBLEMS

From what has already been said of borderline cases, it is evident that they are, as a rule, difficult patients. They demand a great deal more emotionally from the therapist than do ordinary neurotic cases. Their therapy, calling as it does for a more active role on the part of the psychiatrist, is subject to difficulty from the latter's counter-transference attitudes. The therapist constantly has to examine his feelings and reactions in order to be aware of influences at work from his own direction. Work with these patients demands a lookout for attitudes of irritation with the patient and a discernment of the cause, whether rooted in frustrations of one's therapeutic efforts, or hurt to one's own narcissism, or one's own unresolved anxieties. If the therapist is not aware of his significant attitudes from his own previous analysis, the therapeutic situation is apt to suffer. One must observe whether in shifting one's schedule the borderline patient is apt to be chosen for cancellation or for shifting hours. This attitude is readily transmitted to the patient and indicates to him that he is less valued, or more difficult, hence rejected. The patient's subtle discernment of these matters is not always a matter of projection.

Positive attitudes of counter-transference may be less troublesome from the standpoint of management; nevertheless, they can interfere with a dispassionate appraisal of the situation presented by the patient. For example, this may be evident at the start, where one is inclined to favor a diagnosis of psychoneurosis, rather than borderline schizophrenia, because the patient is an

articulate young man, or an attractive or an intelligent young woman. Intellectual or esthetic contact is not emotional contact. The ready flow of material in these cases may deceive one into making technical errors that would militate against the patient's best interests. If we fail to assess the true situation, the psychopathology inherent in the patient's weak and damaged ego structure, there is an ever-present danger of precipitating a frank psychotic reaction through psychotherapeutic endeavors.

Minor irritations can be avoided by realizing the absolute necessity of the most piecemeal work and the inevitability of many unrewarding hours, much tedious material and no great perceptible movement of the case. If one is familiar with the hysteric and/or obsessional variety of borderline case, one is prepared to expect many ameliorations, occasional cures and an inevitable fraction of failures, particularly where the life situation is really bad.

VI

Case Work with Patients and Relatives

IMPORTANCE OF WORK WITH THE FAMILY

In the treatment of transference neuroses, one rarely has to work with the members of the patient's family. In borderline cases, on the other hand, it is almost mandatory to do so, either directly or through the mediation of a social worker. The prognosis generally varies with the life situation, and the worse the level at which this is maintained, the less possibility there is of rehabilitation. One encounters almost as much resistance, dealing with the families of these patients, as with the patients themselves. It is technically almost always better to ask the patient's permission to see his relatives; because of the financial or other dependency of this class of patients on the home situation, it is the family rather than the patient who may interrupt the treatment.

For this reason, although the therapist's alliance is with the patient, the parent or relatives must be brought into more positive relationships, before one can hope to lessen the external pressures on the patient. Generally, much time must be spent in working through the parents' resentment of the therapeutic need and through their interference before any inkling is transmitted that the patient's illness has some relationship to his upbringing. When the opportunity is given to parents to ventilate their feelings about

the patient's behavior, and they are supported in the difficulty that this causes for them, certain minor interpretations of the patient's behavior may be given. It may be assumed that most parents of such patients feel guilty and defensive, and a denial of their role in contributing to the illness may be expected as a natural matter of course. The family generally responds to a request for certain details of the patient's developmental history, and this affords the opportunity for checking on events given by the patient, or forgotten by him. The members of the family may be thus helped to appreciate the patient's difficulty through this indirect focus on development. The relatives must be prepared for expressions of hate by the patient in the course of treatment and for the fact that the patient may temporarily get worse before he gets better. (Especially is this true because of the possibilities of negative therapeutic reactions.)

CASE WORK

Work with the family is not merely auxiliary to the psychotherapy of borderline patients; it is an integral part of the treatment. The change of parental attitudes is not merely a matter of instruction, but one of therapy on a near-psychiatric level. The psychiatric social worker, whether a private or agency worker, is often in better position to work with the family than is the psychiatrist who is treating the patient. Consistent, analytically-oriented work in these directions has been described by Ryerson and Weller.[18]

The case worker can serve an important purpose in the direct rehabilitation of the borderline patient. In such cases, the worker can discuss with young women patients such matters as dress, make-up, home decorating, dating conventions and the like, in a manner that an older sister or a good mother-figure might. While these appear to be trivia to those not handicapped in emotional development, they are momentous matters in the social adjustment of a young borderline patient. The identifications fostered by such relationships contribute considerably toward the patient's progress. The one precaution which is relevant at this point is delimiting the therapeutic function. The skilled case worker will generally meet the patient's introduction of material with a referral of such material to the psychiatrist. The same considerations applying to an atmosphere of easy informality in therapeutic sessions should also apply to case work sessions. These should go beyond

the office atmosphere into such activities as shopping or having lunch together.

A suitable family agency is usually helpful in providing this type of help, which is predicated on frequent consultations with the psychiatrist. Agency limitations, however, may limit the flexibility of the worker in regard to evening appointments, high level of family income, or other practical considerations. The private psychiatric case worker, who works under the supervision of a psychiatrist, can be most helpful in this regard.

VII

Final Phase: Weaning from Treatment Contact

The reduction in the intensity of treatment and the preparation for separation constitutes the third phase of treatment of borderline patients and is considerably more extended than in ordinary neurotic patients. A new adjustment which would take days or weeks in a true psychoneurotic patient, usually takes months in the borderline patient. Gradual progression applies particularly to weaning from therapy, because abrupt termination, or failure to observe each new adjustment over a considerable period invites relapse.

In the psychoneuroses, the aim of the analyst has been the remaking of the personality into a relatively independent one; and, ideally, all vestiges of dependent transference are fully analyzed. In the case of borderline patients, the average goal is that of helping a person with severely damaged ego to function in a good compensatory way on the basis of improved inner understanding.

While continuous therapy to completion is ideal in ordinary neuroses, it is not ordinarily attainable in borderline cases. Discontinuous analysis, in periods to the limit of current adjustment possibilities has been recommended by Bychowski,[10] Flescher,[16] and others. If the therapist does not arrange this, the patient actually does so in practice, when he transcends his ability to "take it." This consideration makes the third phase of the therapy of borderline cases a long-term, if not a life-long, matter.

If the borderline patient has been helped to the point of becoming relatively self-sufficient, and gratified in some endeavors that he previously could not undertake, he has already been helped enormously. In all but the most favorable cases, some restriction

of activities is an expected residue. The best results can naturally be expected in younger patients who are accessible to modified analytic effort. However, even patients of middle age can benefit considerably from interpretative psychotherapy, if the "neurotic option" of the illness has been long stabilized, and if the life situation is favorable.

Summary

The class of patients who are descriptively neurotic but dynamically psychotic makes up a large proportion nowadays of those seeking psychiatric treatment, particularly in private practice. These patients present not only the challenge of differential diagnosis, but the resultant problem of differential treatment which avoids the danger of precipitating frank psychosis.

This paper considers the special therapeutic problems of the borderline group; illustrates differences in the technical handling of given material in these as against true neurotics on the one hand and frank schizophrenics on the other; and outlines the rationale for a comprehensive plan of differential treatment. The premises on which the outline of psychotherapy is based are discussed in relation to the nature of the therapist's relationship, the kind of interpretations given and the goal of treatment.

Attention is called to selective measures required in regard to (1) fantasy, (2) hostility, (3) homosexual material, (4) acting out, and (5) suicidal impulsions. Specific auxiliary measures are presented in relation to work with families of such patients.

The differential therapeutic procedures outlined in this plan can be utilized, to a large extent, by therapists of diverse theoretical orientations.

1212 Fifth Avenue
New York 29, N. Y.

References

1. Hoch, Paul, and Polatin, P.: Pseudoneurotic forms of schizophrenia. Psychiat. Quart., April 1949.
2. Piotrowski, Z., and Lewis, N. D. C.: An experimental Rorschach diagnostic aid for some forms of schizophrenia. Am. J. Psychiat., 107:362, November 1950.
3. Woltmann, A. G.: Personal communication on 50 cases examined between June 1949 and March 1950.

4. Oberndorf, C. P.: Failures with psychoanalytic therapy. Chapter 2 in: Failures in Psychiatric Treatment. Paul Hoch, M. D., editor. Grune & Stratton. New York. 1948.
5. Federn, Paul: Principles of psychotherapy in latent schizophrenia. Am. J. Psychother., 1:129-145, April 1947.
6. Stern, A.: Psychoanalytic therapy in borderline neuroses. Psychoan. Quart., XIV:190-199, 1945. Transference in borderline neuroses. Psychoan. Quart., XVII:527-529, 1948.
7. Schmideberg, M.: The treatment of psychopathic and borderline patients. Am. J. Psychother., 1:45-71, January 1947.
8. Fromm-Reichmann, F.: Principles of Intensive Psychotherapy. University of Chicago Press. 1950.
9. Fenichel, O.: Psychoanalytic Theory of Neurosis. Norton. New York. 1945.
10. Bychowski, G.: Therapy of the weak ego. Am. J. Psychother., IV:407, July 1950.
11. Rosen, J. N.: The treatment of schizophrenic psychosis by direct analytic therapy. PSYCHIAT. QUART., 21:3-37, 1947.
12. Eisenstein, V. W.: Psychodynamic significance of the first conscious memory. Bull. Menninger Clin. (in press.)
13. Eisenstein, V. W.: Dreams following intercourse. Psychoan. Quart., XVIII:154-173, 1949.
14. Freud, Sigmund: An Outline of Psychoanalysis. Norton. New York. 1949.
15. Fenichel, O.: Neurotic acting-out. Psychoan. Rev., XXII, 1945.
16. Flescher, Joachim: Discussion at the psychiatric forum-group, New York City, March 8, 1950.
17. Bergler, E.: The Basic Neurosis. Grune & Stratton. New York. 1949.
18. Ryerson, Rowena, and Weller, Elizabeth: The private practice of psychiatric case work. News Letter, Am. Asso. Psychiat. Social Workers, 16, 1946.

PERSONALITY CHANGES AFTER TOPECTOMY

BY PAUL H. HOCH, M. D.*

Manifold personality changes after topectomy and similar brain operations have been described in the literature. Some accounts of these changes have been confusing because the amount of time elapsing between the operation and the observations recorded, was not always taken into consideration. The patients show different clinical pictures immediately after operation, a few months afterward, and a year or more after operation.

During approximately three to six months after operation any or all of the following personality changes may be present and may occur in any sequence:

(1) Some patients remain alert, clear, and in good contact with the environment. This is usually seen in patients suffering from intractable pain, psychoneurosis, or depression, or in patients who, if they suffer from schizophrenia, are well preserved and have had no deteriorating symptomatology.

(2) Lethargy, apathy, indifference, and blandness are present. This is usually seen in older patients, especially when some arteriosclerosis is present, or in schizophrenic patients with symptoms of deterioration.

(3) There is euphoria with overproductivity, outspokenness, and amorousness.

(4) There is irritability with overproductivity, outspokenness, and belligerence.

In addition, the following findings are usually present. First, there is paucity of associations—the spontaneity of mental production is limited. Second, the attention span is limited. Third, concentration ability is impaired. Fourth, some impairment of recent memory is present. Fifth, few or no dreams are reported, or if dreams are present, they are poorly recalled. Sixth, a fair proportion of patients show emotional blunting. Seventh, they show inertia to activation—when pressed to do something, they do not co-operate well. The aforementioned clinical factors are observed whether or not there is evidence of relief of symptoms.

It is important to emphasize that marked individual differences are present which do not depend so much on the diagnostic classi-

*Presented at the Interhospital Conference of the New York State Department of Mental Hygiene, Central Islip State Hospital, June 22, 1950.

fication of the patient as on the previous personality structure. In the foregoing, only personality alterations which occur relatively frequently were mentioned with a number of personality changes, which are unusual, omitted. A few months after operation, many of the manifestations reported here are no longer present or, if so, only to a moderate degree. If a patient is examined a few months after operation, the personality changes can be grouped under two headings: beneficial changes and detrimental ones. The beneficial ones in general are: (1) reduction or elimination of anxiety and tension; (2) of depression; (3) of hysteria; (4) of obsession; (5) of hallucinations and delusions; (6) of catatonic muteness, rigidity, and so on; and (7) of schizophrenic disorganization symptoms such as incoherence or other thought disturbances, which improve or disappear only if the patient is not too deteriorated. If deterioration is present, these schizophrenic symptoms are not usually influenced very much. This is especially true in apathetic, driveless, simple, or hebephrenic schizophrenics.

The detrimental personality changes which we see are: (1) Dulling of affect, apathy, and inertia do not disappear but remain prominent in the clinical picture; (2) spontaneity and, most likely, creativity are impaired; (3) irritability and aggressiveness are present; (4) the patient shows a psychopathic-like disinhibition in social relationships; (5) in some schizophrenic patients, the basic disturbances of schizophrenia, autism, dereistic thinking, become more pronounced even though some other manifestations such as hallucinations or delusions improve.

The writer would like to illustrate some of the given points with a few very abbreviated case histories.

Case Histories

M. D. (No. 1). During a four-year period prior to operation this patient was very tense, phobic, then increasingly depressed with fears of harming or killing herself. A few months after operation, symptoms of tension, depression, and the phobias were no longer present. She was able to be alone at home, to travel alone, and was no longer depressed or had suicidal ideation. She is at home and functions well. No detrimental personality changes are present. In this patient, anxiety, tension, and depression have been eliminated by the operation.

M. D. (No. 2). Continually tense and anxious for many years M. D. had episodic shaking and tremulousness of the throat and head, at times spreading to the entire body. At such times she had had to hold to a chair to be able to stand. Five months after operation she was no longer tense and anxious, and the shaking disappeared completely. In this patient, the hysterical symptomatology which was in the foreground has been completely eliminated by the operation and no detrimental personality changes are present.

S. G. Here is a 21-year history of emotional upsets, anxiety, tension, fear of sleeplessness, depression, and a 17-year-long history of progressive obsessive, phobic behavior despite intensive psychotherapy and electric shock therapy. Prior to the operation, this patient had many clothing, time, and color taboos, and complicated de-contamination rituals, involving hours spent touching, spitting, and washing. A year after operation, she made a good adjustment in a clerical job, living by herself. All her symptoms had disappeared. With the exception of a very slight shallowness of affect, she shows no detrimental post-operative changes.

A. S. This patient had episodes of catatonic behavior with stiffness, muteness, perplexity, bizarre delusions, auditory hallucinations, restlessness, and depression. There was a suicidal attempt before his present hospitalization. A few months after operation no delusions or hallucinations are present. He is sociable, and well behaved, still somewhat perplexed. The affect which he shows is superficial. Thought processes are simple, and there is an inclination to handle everything literally. In this patient, hallucinations, delusions, and catatonic manifestations were eliminated. The patient, however, remained emotionally impaired. It is most likely that the emotional alterations which are seen here post-operatively are not due to the operation but are residuals of the schizophrenic process which was not completely eliminated.

J. M. This patient had many obsessive-compulsive symptoms. After operation he lost these symptoms but became euphoric, demanding, indifferent, and careless. He developed a devil-may-care attitude which was very different from his previous life approach. However, he is no problem at home. His affectivity is blunted, his energy is reduced, and his social awareness is impaired. In this patient the obsessive-compulsive symptoms were eliminated by the operation; but detrimental personality changes were produced.

These personality changes, however, do not create any suffering for the patient but are quite annoying to others in the environment.

C. C. In the last five years prior to the operation, C. C. had marked tension, anxiety, phobias, guilt, marked depression, and unreality feelings. Hostile and aggressive impulses were present below the surface, but were easily controlled. Six months after operation, he is free of symptoms of tension, of phobias, and of depression. However, he became increasingly irritable, verbally explosive, threatening, and insulting, held many jobs for short periods after operation, either quitting or being "fired," usually in association with an argument. In this patient, the operation eliminated the symptoms he was suffering from, but impaired the control which existed concerning his hostile and aggressive attitude toward the environment; and he is now disinhibited and more difficult to handle than previously.

R. Z. For many years this patient was asocial, aloof, resentful, suspicious, irritable, and distractable. Her affect was blunted and inappropriate. After operation she showed improvement, losing many of her somatic and hypochondriacal complaints and suspicions. However, a certain amount of childishness and autistic behavior persists.

* * *

In these patients the operation eliminated somatic delusions and hypochondriacal ideations, but the basic schizophrenic symptomatology of emotional blunting, childishness and autism remained or became even more pronounced.

After eight months or a year, many symptoms, many detrimental personality changes as just described, disappear or become markedly attenuated. In some patients, however, they appear to be persistent or probably become even permanent. There has not been sufficient time for follow-up studies to state how permanent these personality changes will be. In some patients one sees improvement in their conditions and diminution of personality changes up to a year or a year and a half after operation. On the other hand, relapses occur most frequently in the same period.

If we scrutinize the outcome in patients who have topectomy, we see a wide variety of responses. There are patients who are completely relieved of their symptoms, having no defects produced by the operation. Other patients are merely improved, with no defect symptoms. Again others show improvement in their anx-

ieties, obsessions, and so on, but with defect symptoms in other areas; and, finally, we see patients who are unimproved with or without defect symptoms.

The question that arises is why some patients improve and others do not; why some patients after initial improvement relapse; why certain patients develop personality symptoms after operation, while others develop none or develop them only to a slight degree. It must be frankly stated that we do not know why and how these variations of response occur. There are many speculative explanations but no satisfactory physiological or psychological theory has emerged which would explain all the phenomena involved. Some observations have been made, however, which permit us to evaluate some of the clinical factors.

The patients who respond best to topectomy, and the same thing is true of lobotomy, are patients suffering from a chronic, obsessive or phobic type of neurosis, depression, chronic hysterical manifestations or pseudoneurotic forms of schizophrenia. The duration of sickness in these patients does not affect the outcome. A high percentage lose their symptoms and function well in the community. This is especially remarkable because, before operation, they had received all other available therapies in psychiatry; insulin and electric shock, psychotherapy, and, some, many years of psychoanalysis, without response. In these patients one can speak about curative results. Some well-preserved schizophrenic patients, especially those of the chronic paranoid and catatonic group respond similarly if not quite so well. We would like to call attention again to the previously-mentioned observation that serious defect symptoms are seen much less often in these patients after operation, as compared with deteriorated schizophrenics. We do not know why this is the case, and further research is indicated in this area. The results with topectomy in chronic schizophrenics, especially those with symptoms of deterioration, are not very impressive.

Similar observations on lobotomy patients have been made by many other workers, most recently by Greenblatt, Arnot, and Solomon on the large material of the Boston Psychopathic Hospital. Many of these schizophrenic patients show what we would like to call an "administrative" improvement. The symptoms are not removed all around but some symptoms are palliated or relieved. Many of these schizophrenic patients remain basically as schizo-

phrenic as before the operation. But the impact of some of the symptoms, for instance, hallucinations and delusions, is markedly lessened. Usually they do not display as much aggression and appear to be happier because their tensions are reduced. They are often able to live outside the hospital and engage in some work. This achievement should not be minimized, but it is not comparable to the excellent results seen in many of the chronic neurotic and non-deteriorated schizophrenic patients.

These findings indicate that schizophrenic patients should be operated upon before they deteriorate. The optimum time for the operation for schizophrenic patients is not reliably determined, but our experience with chronic deteriorated schizophrenics on the one hand, and with well-preserved schizophrenics on the other, would indicate that the time of the operation as practised today is often wrong. We should not operate on patients who have not been sick at least a year and a half, because, otherwise, the spontaneous remission statistics will confuse the operative results; but, after being sick uninterruptedly for one and a half or two years, the majority of schizophrenics do not change. If they have failed with other treatments, they should then be operated on before they deteriorate. The present practice of waiting five or 10 years for operation on these therapeutic failures is not advisable.

In this connection we would like to mention the fact that operations like topectomy and undercutting do not damage the personality excessively. Even though the psychological tests available today are not fine enough to demonstrate all the intellectual and emotional alterations occurring after topectomy, clinical experience bears out the psychological findings that gross damage is very rarely produced. Further research, however, is very much needed to determine whether even smaller and more circumscribed operations may produce optimum results with the least damage. We do not believe that extensive personality damage is concomitant with good therapeutic results.

The question is always raised: How does psychosurgery alter the personality? A great deal of investigative work will have to be done before this question can be answered, especially as we do not know a great deal about the origin of most of the mental disorders in which psychosurgery is used. We feel, based on our investigations, that psychosurgery is a quantitative treatment and not a qualitative one. Many of the underlying conflicts in the pa-

tient remain unimpaired, but somehow the patient does not perceive the conflicts any more and is not disorganized by them, thus permitting him to function.

By the use of different drugs, such as mescaline, it is possible to activate neurotic anxiety or psychotic symptoms in many patients post-operatively. The qualitative organization of the symptoms is the same as before operation; but, quantitatively, the impact on the patient is markedly reduced. This quantitative reduction of symptoms, however, should not be interpreted as a purely symptomatic effect. In carrying out psychosurgical procedures we still have to strike a balance between beneficial and detrimental symptoms produced by the operation; but since the introduction of topectomy, consideration of the detrimental symptoms is becoming less and less and we hope will be further reduced.

New York State Psychiatric Institute
722 West 168th Street
New York 32, N. Y.

PSYCHOLOGICAL OBSERVATIONS ON PSYCHOSURGERY PATIENTS*

BY CARNEY LANDIS, Ph.D., D.Sc.

It has been the writer's privilege for the past four years to be a member of a research team engaged in the combined venture of trying to apply the best methods of medical science to the problems of psychosurgery, particularly the changes which are brought about in psychosurgery. May it be said immediately that the writer does not believe that any project has ever been carried out under more favorable circumstances, at least as far as adequate financial support and adequate technical personnel at the disposal of the research team was concerned. Any flaws which may have grown out of the work are, in the writer's estimation, to be attributed to a lack of ingenuity or intellectual ability on the part of the responsible investigators rather than to any lack of support.

What I have to say may be taken up in the form of three different considerations or problems. First, what does not happen; second, what does happen, and third, what still remains to be determined. We may begin by considering briefly what does not happen psychologically after frontal lobe psychosurgery has been done in any of a variety of ways with mental patients or with patients suffering from intractable pain. As you know, the past 50 years has been a period when everything which was not clearly a function of some other part of the human organism has been attributed to the frontal lobes. This portion of the brain has been held to be the seat of highest intellectual ability; the lobes have been called the greatest achievement in evolutionary progress; the frontal cortex has been said to be the measure of intellectual development of the human race, and so on and so on. One may speak of this era as that of "the reign of the myth of the frontal lobes." There was never any really conclusive evidence that there was anything very much which was functionally dependent on the frontal lobes, so far as either physiological or psychological functions were concerned. But there were a lot of things which physiologists and psychologists couldn't put anywhere else; and, since no one knew exactly what the frontal lobes were good for, they provided a very handy place to localize or store away speculations that had no other abiding place.

*Presented at the Interhospital Conference of the New York State Department of Mental Hygiene, Central Islip State Hospital, June 22, 1950.

We have examined—following as careful and wide a variety of surgical procedures as are now available—mental patients, comparing their pre- and post-operative performance. Surgically the frontal lobes have been explored in terms of different areas; in terms of whether connections should be severed or the tissue should be removed; or whether the blood vessels serving that tissue should be interrupted. The general consensus at present, is that it does not make too much difference where or what surgical approach is used, in respect to any psychological or personality change which may be brought about.

With two exceptions, one can say that there is very little that happens, which can be shown by psychological or physiological examination, following any variety of frontal lobe surgery. A few alterations which constitute the first exception to the "no change" rule seem best attributed to the more posterior cuts or posterior removal of tissue. There is fairly good evidence that the nearer the surgeon gets to the primary motor areas during the operation, the more apt one is to find post-operative effects which are undesirable. The second variety of change which may occur (if a change does take place) is in the area of morbid emotion or in the way in which the individual handles his emotional life.

Having specified these exceptions, I could go through in detail a very extensive list of things which do not change and things with which you do not need to concern yourself when called upon to give advice to relatives or to patients concerning possible undesirable effects which might follow psychosurgery contemplated for the relief of mental illness. I think one can say explicitly and with full confidence, that psychosurgery does not damage the intellectual life of the patient. There is no evidence from any patients that have been through any of these procedures that there was any reduction in intelligence shown by any of the intelligence tests, performance tests, verbal tests, or combinations of those tests. That is, the personality changes which took place were not to be attributed to changes in the intellectual status of the individual.

There are rare exceptions of persistent intellectual damage, but these are to be attributed to surgical accidents, large-scale hemorrhaging, or inadvertent involvement of the motor areas. In these rare instances we are not sure whether the intellectual loss will persist longer than six months. We have seen only two pa-

tients who at the end of two years were not so good on intelligence test performance as before the operation. One of these patients was a case in which part of the cingulate gyrus (Brodmann's area 24) was involved. She was not a particularly co-operative patient before operation and she was much less co-operative after operation. We never have been completely certain whether there was a real intellectual defect or whether it was primarily an emotional change. The second patient had a translateral lobotomy which presumably was done too far posteriorly.

The changes which one obtains during the first three weeks or month after psychosurgery are of real interest. In most, but not all, patients there is a decrease in mental test performance which was shown best by the Porteus Maze Test. This is a simple paper and pencil test which correlates fairly well as an indicator of intelligence with the more regularly used forms of examination. This test showed rather regularly a drop of one to two years in mental age which was regained during the period of three to six months after operation. No other intelligence test shows that much of a deficit, and those that did show minor losses during the first three weeks after operation showed the loss to be regained completely three months postoperatively. The loss on the Porteus test was due to the fact that the patient during the post-operative period entered more of the complicated blind alleys on the Maze test blanks than he did before the operation. Otherwise stated, the patient after operation does not avoid entering some of the complicated dead-end alleys. Is this a temporary lack of foresight?

We have been teaching and believing for some 20 years that injuries to, or operations done upon, the frontal lobes would result in a change in the ability to do mental abstractions or generalizations or to assume what Dr. Kurt Goldstein has called "the categorical attitude." Most of the psychological tests used as indicators of possible organic damage are based on the assumption that such changes in the categorical attitude are indicators of organic damage to the frontal lobes or to brain tissue. Again, I am willing to say explicitly that with respect to frontal lobe psychosurgery (done without surgical accident), there is no evidence that the operation results in any loss of the ability to do abstractions, make generalizations, see similarities, derive differences, or assume the categorical attitude.

There are no changes in association test performance—done or scored in practically any way one wishes to employ. The general idea of the association test, as you may remember, is that this procedure is a good way to isolate or detect the presence of emotional complexes in the mental life of the psychiatric patient. Since there is a rather startling change in a number of these patients after operation, in that their morbid emotionality is gone, we expected in advance that there would be a marked test change; that is, the words which before the operation were emotionally charged, after operation should not show evidence of emotional charge. Unfortunately for the psychologists there were no regular or consistent changes in association test performance. The tests did not reflect the loss of morbid emotion, when such loss occurred.

We found no evidence of deficit in memory or learning ability. There was no interference with any material of memory, any ability to learn new material or in ability to utilize the methods of learning which these patients utilized before operation.

Several reports have claimed, usually not on a very thorough study, that psychosurgery patients lose creative ability, imaginative ability or high level intellectual ability. Such claims are easy to make and most difficult to prove or disprove. I can report that with respect to the patients that we have examined before operation and have followed for as long as two years after operation, we have not a shred of objective evidence that they are less imaginative, less creative, or have less high intellectual ability after the operation than they had before. I am well aware that this is an area where the tests leave much to be desired. For the most part one must rely upon what one observes or hears about the patient after he has gone back to the community. In every instance where any information was available it failed to indicate evidence of loss in these highest levels of ability.

We found no evidence of changes in ability in estimating time or judging time. We found no regular changes in any of the Rorschach scores. We found no aphasic symptoms produced in any patient. We found no changes in lateral dominance. We found no changes in tests of the sense of humor. So far as we could tell, these postsurgery patients were just as appreciative of humor after as before operation.

No patient studied in the brain research projects could be characterized as a post-operative "zombi." It is possible that if one

does two or three brain operations on the same patient, or if the operation somehow involves the primary motor areas, a zombi might be produced. Fortunately we never obtained such a result.

These negative findings are matched in completeness with the negative findings in all of the physiological and biochemical measurements and by all of the measurements of autonomic nervous system function. That is, the physiologists, the biological chemists and the psychologists all came out with large collections of negative data as far as verification of previous claims of frontal lobe function were concerned.

What did we find in a positive way? Everyone who has dealt with the psychosurgery patients has been impressed with the fact that *something changes.* The literature is most controversial as to what that something is. Three words have been proposed to characterize the changes which we think we found and for which we think we have evidence. I am willing to admit that our data can be grouped otherwise, and that certain other names or words which are slightly different might be more satisfactory than the three which we employ. We sought these terms and chose them because each has a rather limited meaning and usage. The three words are *vigilance, anguish,* and *zeal.*

By vigilance we mean the opposite of sleepiness; that is, a state of wakefulness. These patients during the first post-operative month (most, but not all of them) showed a marked decrease in vigilance; that is, they were somewhat "dopey," acting as if they were a little sleepy. If one applied enough pressure they could do our tests, but they often made such remarks as, "Look, doctor, I'm sick," or, "I am too tired to do this." They found excuses and made evasions. Usually this is a marked feature during the immediate post-operative period. It is not related to the site, extent or method of operation. It is a generalized inefficiency of function; or a generalized lack of ability to handle problems in an adequate fashion. These patients handle problems much as a sleepy man would handle them.

The second change is that of loss of anguish which is, of course, the most striking of all the changes brought about by psychosurgery. Essentially it constitutes the *raison d'être* for psychosurgery. By anguish, is meant a state of morbid emotion in which the individual is overwhelmed with either sensible or senseless emotion. In many patients either immediately after, or during

one or two months following, operation, anguish or morbid emotion disappears. One must be careful at this point in specifying that the "normal" emotional life of that patient is unchanged. The patient can still get angry; still fall in love and get married; still have a fight with his wife and get a divorce. The emotional life of the patient as far as everyday events are concerned has not been changed. What has changed is the morbid emotional state, anguish. It has actually happened that patients have climbed off the operating table and said, "Doctor, I am well: it's gone!" Such dramatic changes don't happen very often, but we have seen them occur. The more usual thing is that during the course of one to three months after operation, the patient slowly loses the anguish, the fears, anxieties, and tension which were overwhelming him and which constituted the psychological core of his psychosis.

Why is it that this loss of anguish is not shown by all patients? Why is it shown by only a fraction of patients? This loss of anguish is not related systematically to any particular area of the frontal lobe which may have been involved by the surgery. It is not solely related to any one of the psychiatric diagnostic groupings. It is not regularly related to the length of illness of the patient. It is not completely related to any one factor or combination of factors which we can specify at the present time. But even more baffling is the fact that some of these patients who lose their morbid anxiety or anguish, relapse; and when they relapse, they have the same anguish, the same symptom picture, which they had before operation. Where was the anguish during the intervening months? If the operation removed the anguish, it should have come out with the excised tissue. Seemingly the anguish hid while the surgeon was around and then later made its appearance when the threat of the scalpel was no longer imminent.

At this point one must, I think, come to the conclusion that the operation is secondary to the recovery from psychosis. The operation starts some other effect which, when that effect gets going, relieves the anguish. The operation seems to boost the patient into some other physiological state which does not have anguish as its psychological concommitant. I must quickly admit that I don't see how such a physiological change is possible in the cases of the individuals who crawl off the operating table and say, "It is gone." Such rapid changes are most unusual in physiology. Furthermore, in some patients who relapse, the return of the an-

guish is most rapid. They were well; they were comporting themselves in a normal fashion; they went to bed; and they awakened the next morning with the same anguish which had kept them in a mental hospital for 10 years before psychosurgery.

The last of the three terms which we use to characterize the changes is zeal. By zeal, I mean ardent enthusiasm and active interest. For some of these patients, after operation and particularly after they get back into the community, we have received the report that they were more easy-going; that they do not seem to care whether school keeps or not; that whether they work today or not doesn't make too much difference; or the fact that the dishes are left stacked in the sink for three days doesn't seem to bother them. According to their families this is a new feature. Before they were taken ill mentally, they had been more conscientious and more zealous. Now they are a little too easy-going.

It is our impression, and this is only an impression, that this change in zealousness is more marked in the patients in which the more posterior operations were done, and occurred least of all in the patients in whom transorbital operations or topectomies limited to the frontal poles were performed. The scattered and not too relevant reports given by families or associates of patients who have "recovered" and left the hospital form the basis of this opinion. We have no test material which is indicative of any change in zealousness.

In general, it is our present opinion that the changes which are brought about by psychosurgery are mostly transient, and they are related to the operation. We do not know of much evidence which indicates any specific association of change and frontal lobe area or connecting fibers, amount of tissue or method of operation. The loss of vigilance and possibly the change in zeal form the basis of the clinical impression of "minor organic symptoms."

Finally, three remaining points appeal to me as of real importance, points for which I believe further crucial evidence must be collected. First, we badly need, and if possible must devise, tests, examinations, rating scales, or methods of history-taking which will enable the physician to say ahead of time, "If you do psychosurgery on this patient, the chances are great that he will respond favorably (or unfavorably)."

We think, and this is argument of the circular variety, that, knowing what we know now, we can score the tests which were

given before operation in such a fashion that they will differentiate between the patients who got well and remained out of the hospital two years or more, and the patients who didn't get well and never got out of the hospital. Explicitly, however, we have scored these tests so that we forced a separation of the scores. Now all we can do is to wait two years for the next group of operated patients to come through and then see if our scoring system—applied to the psychological tests which we gave before operation—give differential scores a second time. The chances are they will not, but the procedure simply must be followed through. The reason I say the chances are that they will not be too successful rests on the fact that there is no clear logical or psychological connection between those tests which seem to predict and those which fail to predict.

Second, we need a good deal of information on what happens to convalescent or recovered patients after they leave the hospital. We should know how they behave in the community and in family life. We are going to have to determine what their legal status may be with respect to the community. Will they be held fully responsible for their acts? A brain operation was performed which restored an individual suffering from a chronic and presumably hopeless psychosis, back to the community. Essentially we have said when he left the hospital, "God bless you; you are well now; here our responsibility ends." But does it? Unfortunately, we do not know very much about the circumstances which govern so-called relapses or which govern the fact that certain patients are kept at home while the neighbors insist that they are "as crazy as they ever were." We have been relying on hearsay evidence with no systematic reporting of the point. We certainly must have pertinent evidence from follow-up studies.

Third, we must have, collected and placed at our disposal, real information on what the patient who has been subjected to psychosurgery should be warned against or encouraged to do after he is restored to the community. There is any amount of conflicting report as to the amount of responsibility these patients can or cannot take; as to the position which they should or should not assume in the family; as to the amount of responsibility that they can take in a job situation; as to this or that circumstance which presumably should help to keep them out of the hospital; that is, to maintain the sanity which has been returned to them. We really

have no pertinent information on such points. Psychosurgery at present is in not too good repute, because we have had too many relapses, and we do not know why these relapses occur. We do not know whether they "just happened"; whether they have been due to the fact that too much responsibility was placed on the person; or, whether the relapses were due to the fact that some patients have been sent back into a bad home situation. Systematic information on such points is totally lacking. Our evaluation of psychosurgery will remain uncertain until better information on such points is available.

If I may summarize, then, I would like to say that most of the changes which people feared would result if we did surgical operations on the frontal lobes did not happen. Second, the changes which did occur are rather general in nature and may be spoken of as decreases in vigilance, anguish and zeal. Third, we certainly need information as to what happens to these psychosurgery patients during the years after they have been restored to the community.

New York State Psychiatric Institute
722 West 168th Street
New York 32, N. Y.

NEUROTIC HELPLESSNESS IN THE "MASOCHISTIC SITUATION IN REVERSE"

BY EDMUND BERGLER, M. D.

There are neurotics who spend their emotional life in constant unconscious repetitions of the banal masochistic fantasy "bad mother mistreats me." Having unconsciously concocted the framework of "mistreatment"—e. g., by choosing a shrew, or leech-like wife of the reproachful type—they rebel constantly in futile pseudo-aggression; that rebellion is but the inner alibi for "sticking it out" for decades. Consciously, of course, they consider themselves innocent victims of unhappy marriages.* The situation is too well known to warrant further elaboration.

There is, however, one form of these relationships which should be stressed: "the masochistic situation in reverse." The writer suggests this term for a neurotic setup in which the husband—in pursuit of his pseudo-aggressive "rebellion"—is confronted with his wife's martyred *facial expression,* an attitude which immediately renders him completely helpless. The accompanying feeling is one of hopelessness, of "being stopped," of half-fury; the result is an apology and a complete "giving in." Many neurotic wives achieve with precisely this simple technique anything they want from their otherwise rather abusive husbands. It is a technique that does not even require spoken words: A facial expression, a hopeless movement of the hand, the "tearful eyes of a beaten puppy" are sufficient. The question arises: What is the meaning of this helplessness in the husband, and why is this worn-out technique so successful?

As long as the type of neurotic represented by the husband gets his "daily dose of injustice," which he counters with the unconscious alibi of fury (representing but pseudo-aggression**), all goes well. The reason is that, on the one hand, the end-result of the infantile conflict which in these cases happens to be psychic

*For a compilation of these cases, see the writer's books: *Unhappy Marriage and Divorce* (Int. Universities Press. New York. 1946); *Divorce Won't Help* (Harper. New York. 1948); *Conflict in Marriage* (Harper. New York. 1949).

**For differentiation of real and pseudo-aggression, see "Differential Diagnosis Between 'Normal' and 'Neurotic' Aggression," Quart. Rev. Psychiat. and Neur., I:I, 1946. Reprinted in *The Battle of the Conscience* (Washington Institute of Medicine, Washington, D. C. 1948).

masochism,* is enacted, and, on the other hand, the inner conscience is appeased by conscious suffering and defensive fury.

Not all goes well, the moment *the roles are reversed.* Then, the wife immediately *invites in the husband the unconscious identification of her with the fantasy of the "mistreated" child, which in turn leaves the real husband in the situation of the "cruel" mother.* Generally, in these peculiar marriages, the wife is unconsciously requested to act the "cruel" mother, the allegedly victimized husband repeating the act of the "mistreated" child. In the "masochistic situation in reverse," exactly the opposite happens —the "mistreated" child being pushed into the situation of the tormentor. This is more than this neurotic can stand and more than he has bargained for: His inner conscience accuses him of playing the part he "hates" most—that of the "cruel" mother. To "keep in the act," the original situation has to be restored. It is —until the next instant.

To increase the irony of the situation, the poor husband accuses himself consciously of being "too aggressive" toward his poor wife. His inner guilt, genetically belonging to unsolved psychic masochism, is thus shifted to the pseudo-aggressive defense. By "taking the blame for the lesser crime,"** the whole neurotic battle is fought and lost on a spurious front.

From the practical aspect, the helplessness resulting from the "masochistic situation in reverse," accounts for perpetuation of these neurotic marriages. The husband asserts that he is incapable of untying the Gordian knot—his guilt because of his "cruelty" makes him helpless.

* * *

Here is a representative example, one of many observed. Mr. A. had been married for 34 years. This was his description of his wife:

"She was a good looker and the brightest girl, with a truly photographic memory. One of those kids with the college stigma, 'most likely to succeed.' Well, she wasn't so smart in marrying me. What she really wanted from life was a penthouse, a mink coat and real financial security. Personally, I don't care much for money; I even get bored with success. I had my up's and

*Details in *The Basic Neurosis* (Grune & Stratton. New York. 1949).

**See Chapter III, "The Nine-Point Basis of Every Neurosis," in *The Basic Neurosis,* l. c.

down's, mostly down's I must admit. The truth is that I never offered my wife what she expected, instead mostly a lower middle class existence. As a personality, she is rather contradictory. I always considered her an immature, child-like person.

"My daughter finally convinced me that she could not have been such a harmless weakling as I considered her to be. She believes her mother had a cruel streak. As far as I can make out, my wife is an infantile person who never grew up. As far as her aggression is concerned, I cannot detect much of it. Only if you enlarge the meaning of the term and include a certain leech-like quality, an attitude of seemingly helpless hanging-on, combined with a reproachful, 'don't leave me alone,' could I consent to my daughter's description, and even then only with reservations. The keynote of my wife's personality seems to me her child-like quality. That's exactly what irritates me most: infantile bragging with learned words, holding the spoon like an adolescent girl and trifles like that. That infantilism irritates me more than the fact that my wife's interests and mine are completely different."

As usual, facts and the patient's perception and evaluation of these facts, did not coincide. In the course of analysis of his marital conflict, it became clear that the patient—a deeply masochistic person—had married an aggressive woman, patterned unconsciously after his matriarchal mother. She was, more precisely, patterned after a *caricature* of his real mother. The latter was an aggressive and domineering woman with intellectual aspirations, backed up by little real knowledge. The patient's wife, however, acquired a great deal of book knowledge, but "could not think," as the husband complained. What he meant was his wife's inability to connect facts intelligently; she could only recite. Hence his wife's actual knowledge on diversified subjects proved to the patient her "being different" from mother. This "improvement" was counteracted by his wife's inability to use her "Information-Please" knowledge intelligently. The latter quality thus represented an unconscious irony directed by the patient toward all of his mother's pseudo-intellectualism.

The same technique of slight improvement as alibi, covering continuation of masochistic attachment by a thin layer of pseudo-aggression, was also visible in the way the patient coped with his main neurotic problem: the wish to be aggressively treated by his mother and her later representative, his wife. Mother was "out-

right" aggressive, his wife was not, at least not in relation to him. Her technique was more subtle. She displayed a "possessive" quality by "clinging" and martyrdom. The results were no less torturing.

In another layer, that clinging quality represented the patient's own infantilism and "sucking-in" tendency. In unconscious identification with his wife, *he* was the martyred child, also acting at the same time, in double identification, the role of the refusing mother. In other words, the patient was unconsciously acting both parts in his marital pantomime: that of the tantalized child and that of the tantalizing mother. It was a perfect masochistic, and (at the same time) defensive, set-up. In living out the role of the mistreated child, the masochistic wishes were fulfilled. In acting the part of the "bad" mother, he proved to himself his pseudo-aggression as his alibi, and, at the same time, demonstrated, in a caricature, her "cruelty" to the mother. There was only one drawback; the unconscious narcissistic identification of his wife with himself, as the masochistically-victimized child, made it impossible for the patient to put up any resistance at all to his wife's real and unwarranted demands.

By the simple trick of acting complainingly, she could achieve everything with the husband. He felt "terribly guilty" when he refused anything, e. g., objected to her unreasonable demands on his time. "Don't leave me alone," was for her the magic formula which worked on the patient with the precision of "Open, Sesame." The reason for his "weakness," as he called it, was understandable: Officially, the patient believed that he mourned in his childhood over his mother's detachment, coldness, and lack of love, leaving him to his own devices. Since he unconsciously identified himself with his wife, every refusal—unconsciously—meant: *"What right have you to act the same refusal against which you objected when mother administered it?"*

To complicate matters, the patient had to perform two other tasks, too. First, he had to use considerable psychic energy in the cathexis of holding down the masochistic enjoyment of the whole domestic set-up. Second, he had to provide a pseudo-aggressive defensive façade: Hence he felt angry and irritated with his wife. He managed to railroad himself into the grotesque situation that whatever he did with his wife caused him discomfort. Confronted, e. g., with the wish to spend an evening outside

the home with friends, he was torn between the Scylla of feeling "terribly guilty" when leaving his wife alone even for one evening and the Charybdis of feeling irritated when finally sacrificing his wish to go out.

Partly because of her own neurosis, partly in an intuitive understanding of her husband's inner wishes, his wife isolated herself completely. She had no friends, no acquaintances, and had a neurotic fighting relation to her daughter. The result was that she could point out that the husband could not "leave her alone."

The patient learned early, and the hard way, that one cannot do business with the inner conscience, though he did not understand consciously what was really going on or "what hit him." His unconscious conscience was well aware of the infantile double game (like an actor playing, in different disguises, two parts in the same play) which he acted on the marital scene. To counteract the chronic reproach of conscience, objecting against his hidden masochistic pleasures, he had to mobilize pseudo-aggression: hence his relative lack of financial success, which unconsciously enabled (consciously forced) him to deprive his wife of her dreamed-of triad of penthouse, mink, and security. He damaged himself, too, but that is exactly the masochist's inner aim. That aim is unconscious, hence it does not prevent but, on the contrary, even produces, a great deal of self-accusations, complaints, and pity. Another technique of camouflaging his masochistic pleasure-gain in marriage, consisted of chronic irritation with his wife.

The irritating trifles were intimately connected with his whole psychic situation. In his wife's bragging in complicated and outlandish phrases, he immediately identified himself with the allegedly "humiliated" listener, and therefore acted out his unconscious wish to be masochistically mistreated. In his wife's adolescent handling of her spoon, though she was already an elderly woman, he was reminded of her infantilism. That, in turn, reminded him unconsciously of his own infantile behavior, the reproach of the inner conscience being: You yourself are infantile. On the other hand, the ensuing irritation represented the alibiing inner defense: "I don't enjoy my infantilism, projected upon my wife, I'm irritated and angry." Both reproach and defense were, of course, unconscious.*

*For elaboration of the psychic importance of "trifles," see Chapter 1, "Malevolence in Trifles," in *Conflict in Marriage*, l. c.

The tragedy of this man consisted in the fact that he had unconsciously chosen as wife a person who represented both a weak ironic replica of his mother's rejected personality traits and, at the same time, a caricature of himself. His wife's leech-like quality, the clinging, infantile attitude, mirrored his own defensive attachment to his mother: "I don't want to be rejected, I want love and attention." In other words, it already comprised defensive elements, used after the stabilization of his infantile conflict which spelled psychic masochism.

Mrs. A.'s pseudo-intellectualism pertained (as used unconsciously by the husband) to the latter's directing of irony upon maternal literary aspirations.

This complicated web of neurotic wishes, defenses, alibis, pseudo-aggressions, etc., was seen by the patient's inner conscience (super-ego), and stigmatized, as years went by, more and more as "fake." Hence A.'s depression and dissatisfaction, his increased need of attesting to himself how unhappy he was, resulting also in greater need for picking on trifles as an alibi.

How extensively A.'s life was dedicated to self-abasement and self-torture, was visible also in another complaint. His wife, so he asserted, admired him without criticism. The majority of men ask for just this trait. A. could not stand praise, because he unconsciously wanted rejection.

The ironically-tinged continuation of the mother-image in his wife, coupled with strong narcissistic-masochistic elements, explained why A. was so helplessly drawn to and repelled by his "impossible" wife. The irritating trifles represented both his attitudes in condensed form.

* * *

The "masochistic situation in reverse," as described here, has extensive practical importance. Without the analyst's familiarity with this mechanism, even psychiatric-psychoanalytic treatment fails to resolve some marital conflicts. It *seems* that the vicious circle of unconscious aggression and unconscious guilt is unchangeable. This is a mirage, based on the confusion between the masochistic substructure, and the covering pseudo-aggression.

251 Central Park West
New York, N. Y.

PERSISTENT ORGANIC AND PSYCHOGENIC SYNDROME FOLLOWING PROLONGED INSULIN COMA

BY ROBERT W. GANS, M. D., AND LEOPOLD P. DEUTSCH, M. D.

Concurrent with the widespread use of insulin in the treatment of diabetes and in shock therapy for the psychoses, there has been an abundance of reviews. The problems arising from insulin therapy have been investigated from various angles. Despite better insight into the mechanism of hypoglycemia, many of the puzzling qualities of recurring or prolonged coma have not been adequately explained. It has been inferred that there are other alterations in the nervous system besides those seen in the hypoglycemic state. Neuropathologic changes of both vascular and cellular character have been described by Ferraro and Jervis.[1, 2, 3] They postulate the functional origin of the vascular impairment.

Although a knowledge of the pathology of prolonged coma is now more accessible because of these studies, the psychological aftermath is beset with many still unexplored facets. In fact, the literature contains conflicting remarks about the frequency and intensity of either transitory or permanent organic or other damage. This will be discussed in greater detail in the course of this paper. In addition, it appears to the present writers that the psychogenic reaction to the organic change has also not been sufficiently elaborated.

The authors will attempt to illustrate some of these unusual features on the basis of a case report of combined organic and hysterical sequelae to prolonged coma.

R. F. is a German-Jewish refugee, who came to the United States in November 1939 when 37 years of age. There is little information concerning her pre-psychotic personality, which was described in conventional terms. However, she was characterized as a person with a pessimistic and depressive outlook who was sensitive to criticism. There were no frank depressive episodes mentioned.

Within a week after her arrival in the United States, she began to show an excessive preoccupation with the hopelessness of her future. She felt worthless and was certain that her husband, a physician, would never be able to resume the practice of medicine; that Hitler would come to this country and gain control. A few

days later she developed a suspicious attitude concerning her food and medication. She seemed frightened and was resistive to every attention. Finally she refused her food entirely, implying that it was poisoned.

On admission to Pilgrim State Hospital on January 3, 1940, she was rather distrustful, sulky, depressed and agitated, requiring tube-feeding. Her behavior was continuously distrustful, with refusal of food after staring at it and smelling it. She was mainly uncommunicative. Subsequently, the acute manifestations subsided, and, with this improvement, she was released from the hospital on February 5, 1941 with the diagnosis of manic-depressive psychosis, mixed type.

Her second hospital admission occurred on September 11, 1942. It was to a private sanatorium, as a consequence of depression, suicidal tendencies and ideas of persecution of a month in duration. She was noted to be rather agitated and resistive. Immediately after admission, she was started on insulin therapy. On October 10, 1942, following her insulin injection, she remained in coma. Thereafter, she was in a protracted coma for several days, but many of the details are lacking. On October 15 she was still semi-comatose and made only feeble resistance to tube-feeding. On October 18 she was still semi-stuporous, moaned and had to be tube-fed. Gradually she came into more contact with her surroundings but talked very little and acted rather childishly. She was discharged as improved on November 1, 1942 with a diagnosis of involutional psychosis, schizophrenic type.

Unfortunately, this hospital's records revealed no more than is outlined here. Further information was obtained from the patient's husband to the effect that severe memory defects, disorientation and amnesia were present on the resumption of consciousness following the prolonged coma. There was no improvement in memory-functioning while the patient was at home. Finally she was hospitalized at another private sanatorium on September 10, 1945 and was found to be bewildered, disoriented and unable to recall most events of the past or immediate present. There were only a few things that she was able to remember correctly—and these with great effort—such as the place and year of her birth, her father's name, her mother's first name, and her husband's name. There was some incorrect recall and, particularly the mention of a child, a boy, four years of age, when actually she had no

children. To most questions, she answered, "I don't know," accompanied by intense knitting of the brows and grimacing. There were no other trends except the helplessness of the patient during the first week or two. The neurological consultant felt that the amnesia had an organic basis "most likely extra-pyramidal tract disease." There was no apraxia or aphasia. The electro-encephalogram revealed no abnormalities. The Rorschach and Wechsler-Bellevue tests indicated intracranial pathology. A second neurological consultant (of prominent stature) felt that the memory defects were functional in origin. She was discharged from this hospital on April 26, 1946, as a case of psychosis without diagnosis, with functional memory defects.

While at home with her husband, she could not be left alone. She would lose herself on the street, not remember where the bathroom was, forget where she put her shoes, and constantly ask her husband to tell her simple things and carry out routine functions for her. Four months before her admission to Rockland State Hospital, she began to manifest many suspicions and fears. She stated that the toilet was not clean and she could not use it; she would ask if the water was O. K. and whether the bed linen was in good condition. She could be reassured, but the next day the whole process would be repeated.

On admission to Rockland State Hospital, October 28, 1946, four years subsequent to the coma, the patient was continuously restless, agitated, crying at intervals, groaning, striking a pose, seeming to indulge in histrionics, holding her head in her hands and grimacing. She kept complaining, "I don't remember, I don't know where everything is, my head is empty." She wandered up and down the hall, was not able to find the toilet section or her own shoes or the water fountain. The affect was one of marked confusion and perplexity. Throughout several interviews she denied any frank trends or hallucinatory experiences. She said repeatedly, "My head is empty, I don't remember, what's going to happen to me." The amnesia revealed itself as a patchy one, a lacunar type involving all spheres of the sensorium, with mixed retrograde and anterograde elements. The memory deficiency seemed to fluctuate. With ego reinforcement and support, the number of failures seemed to decrease.

The general physical examination was not particularly significant. Neurological examination revealed minor signs of a possible

basal ganglia involvement—questionable diminished left arm swing, mild tremor of the head and upper and lower extremities with predominance of the left side, and pseudo-spontaneous movements of the fingers. There was no evidence of sensory or motor aphasia or ideomotor apraxia. A disturbance of foreground and background relationship in evaluation of pictures was elicited but no definite indication of agnosia.

A battery of psychological tests was performed including the Rorschach, the Short Scale Army Test, Design Memory, Ship Test, Healy P C II, Wechsler-Bellevue, Goodenough, Triangle Test, Weigle Test, B. R. L. Sorting, Stanford-Binet L Vocabulary, Healy A, Naming Coins, Timing Orientation and Kent E. G. Y. The Rorschach responses totaled nine and were poor in form level with little elaboration and no attempt to integrate the blot material. Five responses were "butterflies." There were no responses using color; cards VIII, IX and X were rejected; in card III, she pointed to the red areas and said she did not know what they meant. Such a color disturbance seemed to represent a neurotic repression of reactions. The lack of movement response indicated constriction of thought activity and imaginative freedom. Memory defects were so marked that, on returning to the previous card, she had forgotten her response; when reminded of it, she denied it.

The other psychological findings were specifically indicative of slow performance and marked memory difficulty even with the use of her native German. There was occasional success in more difficult items after failure in more simple ones. Perseveration tendencies were also present. The inconsistent and variable feaures of these results could only be explained on the basis of a mixture of organic disorder and hysterical elements.

Other examinations included an electrocardiogram, which was negative; x-ray of the skull, which showed no evidence of pathology and a pneumo-encephalogram, which was done on two occasions with only slight co-operation on the part of the patient. The ventricular system was somewhat dilated but no asymmetry or filling defects were noticeable. The area over the cortex and basal cisternal system was not filled. This represented a picture of a mild hydrocephalus. An electro-encephalogram could not be done because of the patient's restlessness and resistiveness.

Subsequent to admission, the patient became more and more agitated at intervals, crying, screaming at the top of her voice, bang-

ing on the doors and walls, "Give me my clothes, where is my coat, my husband is waiting outside to see me. Why do you keep my husband from me?" Frequently she would be resistive to routine procedures, fighting with the attendants and expressing the feeling that she would be harmed. She was constantly bewildered, out of contact with reality, reiterating inexplicable complaints such as, "Where is my nutria coat, why do you keep it from me?" and, " I must go home, they are waiting for me." Intermittently in the course of her confusion, she would break her glasses and would then remark in hysterical fashion, "I can't see anything, are my eyes open or closed, is it night or day?" She gave many approximate answers, recognized that she was in a hospital but gave the name of a previous private sanatorium. She recognized the ward physician as a doctor but could not repeat his name one minute after this was given. She reiterated that she had never seen him before, even after many interviews. The year was given as 1945 or 1942, years of admission to other hospitals. When her husband visited, she knew him and greeted him pleasantly but questioned what he was doing there. On occasion she would say that her husband was dead and at other times, even during the same interview, state that he was outside waiting to see her or had just stepped down the hall.

Hypnosis was attempted repeatedly but this was always met with a negativistic attitude. After a light trance was established, there would be opposite response to commands. She would then try to rouse herself, fling her arms to the side, rub her eyes vigorously and do everything to prevent herself from losing control of the situation.

She was also placed under the influence of intravenous sodium amytal on frequent occasions. During these interviews she was usually apprehensive. Most of her replies were stereotyped. "My head is empty, I don't remember, what is it with me?" Prior to some of these interviews, she declared that her husband was dead and that she had one, two or four children, attaching different names to them on successive occasions (actually the patient has never had any children). At other times, these statements were repudiated either before taking, or during the influence of, sodium amytal. It was the impression of all observers that she did not make sufficient effort to recall identifying data, which is the re-

verse of typical organic cases, where the effort to co-operate transcends the capacity.

Before outlining our own concepts of this case, an attempt will be made to review the literature in the light of the problems raised. As early as 1939, A. B. Baker made a significant observation, indicating remarkable foresight from our point of view. In discussing cerebral damage in hypoglycemia, he stated, "The neurological and psychiatric phenomena suggest an extensive disintegration of cerebral function." Also, "Damage to the nervous system is not as uncommon as the sporadic reports would lead one to believe. Fatal outcomes from hypoglycemia have filtered into the literature for years, but the slow recoveries and the permanent functional impairments have not been emphasized or possibly not reported, although such cases must occur."[4]

Although Baker's observations were mainly derived from the handling of diabetics, it seems to us that his conclusions are equally applicable to the therapeutic use of insulin with psychotics. Baker[4] describes three diabetics in hypoglycemia, of whom one died and two others showed a mixed aphasia or sensorial disturbance with confusion, memory defects and disorientation of a protracted nature. A fourth case of a schizophrenic, in which insulin was given as shock treatment, displayed, after coma of 24 hours duration, an apparently permanent confusion and misidentification, necessitating transfer to a state hospital. Wechsler[5] reported a case of prolonged coma, in which six months later the patient was still disoriented as to time and place, the memory was defective, and there were marked confabulatory tendencies. It was noted that the patient was highly suggestible. However, the previous paranoid hallucinatory syndrome was absent. Wechsler felt that the entire picture was characteristic of organic dementia.

It should also be pointed out as relevant to this paper that observations have been made on the sensorial disturbances found in cases of pancreatic adenoma. McClenahan and Norris[6] reported a case of hypoglycemia due to pancreatic adenoma, in which attacks of transient amnesia occurred over a period of 18 months. In describing cerebral changes associated with a case of pancreatic adenoma, Malamud and Grosh[7] noted that the cerebral cortex showed distinct parenchymatous degeneration. This patient had suffered repeated "fainting spells" for six years. These gradually increased in severity and, after four years, had produced in

the patient a definite personality disturbance and mental retardation.

Although many other reports have been reviewed, these have not been included in these studies because the writers do not feel that they have a specific relationship to the problems discussed here. Furthermore, recent publications on the complete subject of shock therapies reveal discrepancies in the evaluation of prolonged coma sequelae. Kalinowsky and Hoch indicate that residual damage from prolonged coma is uncommon. In fact, they state: "Memory defects, disorientation and confabulation resembling Korsakoff psychosis have been described and they frequently follow a protracted coma. More usually, the Korsakoff-like condition is present for only a few days or weeks but Plattner has described cases which lasted six months. These patients, however, had also received metrazol. Polatin et al. found that this organic mental condition lasted only a short time. In one patient, however, the electro-encephalogram retained abnormal wave patterns and even after some time the psychological test performance was decidedly inferior to the previous performance. It is possible, therefore, that in some patients organic damage does result from the treatment but it is observed so rarely that it should not be used as a reason for the non-application of treatment."[8]

Sargant and Slater, on the other hand, have this to say, "Mental impairment is of much greater importance after long irreversible coma, and a severe Korsakow picture can result from this. This improves somewhat as a rule but usually leaves greater or lesser degree of permanent impairment."[9] Lester[10] collected 25 cases of prolonged coma, of which four died. His studies revealed, "With the exception of the fatalities, only one case was thought to show any persistent evidence of brain damage." A review of prolonged insulin coma was given by Rivers and Rome[11] in 1944, in which various complications were mentioned, such as a shifting neurological picture, disturbance of the peripheral nervous system, autonomic disorders, convulsions, memory defects and impairment of higher cortical functions. But there was no information concerning the duration of these deficiencies.

Comments

The authors are aware that this review of the literature is not exhaustive. It is assumed that many cases which might fall into

the category of irreversible neurological and psychological impairment have been observed but have not been reported. The writers' own attention has been called to several such cases in this hospital, which are not now accessible to direct study, but an attempt will be made to evaluate the changes in a subsequent report.

From perusal of the literature, the question of frequency, severity and persistence of brain damage in the course of prolonged coma, appears still unsettled. Furthermore, the case presented here seems to be unusual, inasmuch as the complications have persisted for almost six years. Although cases of the Korsakoff syndrome have been mentioned in the literature, this one has features of anterograde amnesia and does not conform entirely to the Korsakoff picture. In fact, the clinical evidence seems to reveal many hysterical features which make a diagnostic dichotomy rather difficult.

In this connection it should be emphasized that the role of emotion in memory, under normal and pathological conditions, has received considerable thought in recent years. Rapaport[12] has shown that amnesia may represent a combined psychogenic-organic reaction. In other words, the patient reacts to the narcissistic trauma of the organic deprivation with psychological manifestations of a defensive or protective nature. In line with this, the Korsakoff patient probably displays an attempt to compensate for his intolerable organic deficiency by means of pseudo-hallucinatory mechanisms, such as wish-fulfillment, displacement, condensation, overdramatization, etc.[13] Is it possible that the emotional reaction to memory disturbances in the course of shock therapies has not been sufficiently elaborated?

Many workers have found that the hidden content in organic and functional amnesia can be eluciated by the well-known means of hypnosis and drugs such as sodium amytal. It remains remarkable that the writers' case, despite a strong functional component, was not accessible to improvement, even with the application of these therapeutic tools.

It is understood that irreversibility of amnesia is considered to be a criterion for organic impairment, but it would appear to other authors and the present ones that this differential diagnostic yardstick does not have an exclusive reliability. The case reported here showed fluctuating variations in co-operative effort and in memory production—with the use of all procedures.

The writers' clinical observations and corroborative psychological test work place this case within the area of mixed amnesia of organic and functional type. The lack of approachability in the face of strong emotional factors may be explained within the framework of the original psychosis. The paranoid features have remained but have receded into the background of the amnesia.

Conclusions

1. A case of combined organic and functional amnesia as a complication of prolonged insulin coma has been reported.
2. The unusual features of this case have been emphasized from the standpoint of the persistence, the nature of the functional component and the inaccessibility of the amnesia to well-accepted therapeutic procedures.
3. Although the literature reveals conflicting views, it might appear that irreversible organic changes after protracted coma are more frequent than implied.
4. The amnesia in the writers' case gave evidence of a marked emotional component. It is felt by the writers that the role of this factor may have been overlooked in other reports and should be further studied, particularly in the face of recent investigations of emotion in connection with normal and pathological variations of memory.
5. The value of amnesia as a repression mechanism has been well illustrated. It is possible in this case that the previous paranoid psychosis has been submerged within the symptoms and behavior disturbance of the amnesia. Perhaps this is responsible for the resistance of the patient to usual methods of treatment.

Rockland State Hospital
Orangeburg, N. Y.

REFERENCES

1. Ferraro, A.: Neuropathologic findings in the brain of three additional cases of schizophrenia treated with insulin. J. Neuropath. and Exper. Neurol., 1:188, 1942.
2. Ferraro, A., and Jervis, George A.: Brain pathology in four cases of schizophrenia treated with insulin. Psychiat. Quart., 13:419, 1939.
3. Ferraro, A., and Jervis, George A.: Pathologic considerations on insulin treatment of schizophrenia. Am. J. Psychiat., 96:103, 1939.
4. Baker, A. B.: Cerebral damage in hypoglycemia. A review. Am. J. Psychiat., 96:109, 1939.

5. Wechsler, Z.: Unusual complication in protracted shock treatment. M. J. Australia, 2:616, 1944.
6. McClenahan, W. U., and Norris, G. W.: Adenoma of the islands of langerhans with associated hypoglycemia. Am. J. Med. Sci., 177:93, 1929.
7. Malamud, N., and Grosh, L. C.: Hyperinsulinism and cerebral changes. Arch. Int. Med., 61:579, 1938.
8. Kalinowsky, L. B., and Hoch, P. H.: Shock Treatments and Other Somatic Procedures in Psychiatry. Pp. 50-51. Grune & Stratton. New York. 1946.
9. Sargant, W., and Slater, E.: Introduction to Somatic Methods of Treatment in Psychiatry. P. 22. Williams & Wilkins. Baltimore. 1944.
10. Lester, D.: A study of prolonged coma following insulin shock. Am. J. Psychiat., 95:1083, 1938.
11. Rivers, T. D., and Rome, H. P.: Prolonged insulin coma in the treatment of schizophrenia. Arch. Neurol. and Psychiat., 51:550, 1944.
12. Rapaport, D.: Emotions and Memory. Williams & Wilkins. Baltimore. 1942.
13. Davidson, G. M.: Psychosomatic aspects of the Korsakoff syndrome. PSYCHIAT. QUART., 22:1, 1948.

TEST EVIDENCE OF PERSONALITY CHANGE AND PROGNOSIS BY MEANS OF THE RORSCHACH AND WECHSLER-BELLEVUE TESTS ON 17 INSULIN-TREATED PARANOID SCHIZOPHRENICS

BY M. B. LIPTON, Ph.D., S. TAMARIN, M. D., AND P. LOTESTA, M. D.

Method

This study was undertaken primarily to explore the nature of change in personality structure directly resulting from insulin shock therapy. The Rorschach and Wechsler-Bellevue tests were administered prior to the onset of therapy and again at the completion of the fortieth treatment. The fortieth treatment was chosen to provide for a sufficient range of variation in responses to treatment and for administrative convenience. All cases received insulin hypoglycemic shock treatment by the Sakel technique. Aside from a consideration of the general test changes presumably resulting from treatment, further validation was sought for a test sign approach for use in prognosis.

The subjects were 17 schizophrenic patients, 15 males and two females. In all cases, the paranoid elements predominated in the clinical picture although one patient had been officially diagnosed schizophrenia, catatonic type. The patients ranged in age from 14 and one-half to 38 years.*

The original diagnosis and final clinical evaluation of each case was done independently of the psychological testing by two psychiatrists whose ratings of much improved, improved and unimproved, as of the fortieth treatment, were accepted as the criterion against which test results were evaluated.

The pooled ratings of the two psychiatrists depended on the following factors. 1. Emotional response—lability, appropriateness, control, mood. 2. Social adjustment—relationship with other patients and ward personnel; degree of active participation in ward activities; attitude toward relatives, friends. 3. Pathological signs—delusions, hallucinations, panic states, etc. 4. Degree of insight. 5. Reality level. 6. Attitudes—of hostility, suspiciousness, etc. 7. Anxiety or tension level. 8. Manifest drive.

*The study was made possible by the co-operation of C. H. Bellinger, M. D., senior director, Brooklyn State Hospital.

The study is divided into two sections. In Section I, test evidence of personality change caused by insulin shock therapy will be discussed. In Section II, a sign approach to prognosis, again utilizing psychological test methods, will be evaluated.

Section I

Test Evidence of Personality Change Following Insulin Treatment

Despite the relatively widespread use of insulin as a means of therapy in schizophrenia, there has been a paucity of investigations using psychological test performance methods.

Previous Test Evidence. Halpern[1] found that the post-treatment scores on the Rorschach test were closer than pre-treatment scores to average norms. More specifically, Halpern noted a generally improved state of affective impulses and a greater hold on reality. In a more recent study, Carp[2] reported no significant changes in Rorschach protocols as a result of insulin shock therapy. With the MMPI, Carp, however, found significant differences on a number of pathological symptom categories. Hales and Simon,[3] also using the MMPI, substantiated Carp's findings in general. On the Wechsler-Bellevue test, Carp reported a mean increase of five points and concluded that the I. Q. in general is little affected by insulin.

The Wechsler-Bellevue. This test was administered routinely to each patient, primarily as an aid in eliminating the clearly defective and organic cases, and with the somewhat faint hope of observing some significant change in the psychometric picture as a result of shock therapy. The writers' experience with the Wechsler served to validate Carp's findings further. The mean difference of pre- and post- scores was 5.95 for the present study as compared with a 5.0 increase reported by Carp. It is accordingly felt that the changes obtained are most easily explained on the basis of a practice effect. It is even possible that the increase observed might in actuality represent a deficit. Derner, Aborn and Canter[4] report an increase of 7.6 at re-testing after a four-week interim and 6.2 after a six-month interim, with normal subjects of comparable intellectual level. Since the duration of treatment under insulin shock therapy is approximately two months, one might expect a somewhat greater increase in I. Q. than is actually obtained.

The Rorschach Test. The most obvious change in the Rorschach picture appears to be a general lowering in the total number of responses. An examination of Halpern's tabulated data supports this conclusion. This difference in the number of responses, pre- and post-treatment is so extensive as to complicate an analysis of the various Rorschach categories and proportions. It is difficult to state to what extent the loss in total number of responses is a function of seemingly significant changes in individual scoring categories. There are, however, two rather salient observations which are suggested by the data. Using an F+% of 70 as a generally accepted critical point, patients after treatment show some tendency to better form-perception but calculation of the exact probabilities indicates that the differences observed, pre- and post-treatment, might reasonably be ascribed to chance fluctuation.

Table 1. Changes in Form Accuracy Perception During Insulin Shock Therapy

	F+%$\overline{=}>$70	F+%<70	
Before shock	10	7	17
After shock	14	3	17
	—	—	—
	24	10	34

By Fisher's exact method.* P is not significant at the .05 level of confidence.

There is also some suggestion of greater control over affective reactions but again, according to the exact method of determining probabilities, the results do not prove significant.

Table 2. Changes in Color Control During Insulin Shock Therapy

	FC$\overline{=}>$C+CF	FC<C+CF	Total
Before shock	10	7	17
After shock	14	3	17
	—	—	—
	24	10	34

By Fisher's exact method.* P is not significant at the .05 level of confidence.

*Because of the small frequencies involved exact probabilities were calculated. (For a description of the technic used refer to: Fisher, R. A.: Statistical Methods for Research Workers. Sixth edition. Pp. 100-102. Edinburgh. Oliver & Boyd. 1936.)

The authors wish to state their indebtedness and offer thanks to Dr. Charles Gershenson, formerly of Columbia University, for assistance with the statistical analysis and computations involved in this study.

Halpern also noted a tendency for a more concrete and practical approach after treatment, as seen in the increased number of D responses and a loss in the W responses. Empirically, the writers' data would not appear to confirm this contention. Reference to Tables 3 and 4 suggests a somewhat heightened D expectancy after treatment but this appears to be caused by a loss among the unusual details rather than among the whole responses.

Loss in Capacity to Respond as a Function of Insulin Shock Therapy. The most parsimonious explanation of change in insulin shock treatment seems to be a general loss in the capacity of the patient to respond. Examination of Halpern's data corroborates these findings. Perhaps even more interesting is the observation that the loss in total number of responses seems closely related to the degree of improvement observed clinically.

The probability obtained suggests that the loss in total number of responses noted as a function of improvement in this experiment might reasonably be expected to occur only once in 100 samples as a result of purely chance variations.

Halpern's tabulated data points clearly to this interpretation but is not mentioned in her analysis of the test findings. One must then ask the question, "Why is observable improvement under insulin shock therapy related to the efficacy of the treatment in diminishing the patient's capacity to respond?" Perhaps those patients who respond most poorly to insulin shock therapy are those in whom there is already organic impairment of a rather fixed nature, and who have already reverted to more primitive modes of reaction and cannot be further incapacitated by the relatively mild assaultive effect of insulin therapy. It is interesting to note in this connection that patients who fare poorly under insulin frequently receive combined shock therapies of a more highly traumatic nature with positive results. Conversely, those patients with the richest personality resources present the most fertile prospect for a loss in the capacity to respond with the apparently attendant correlate of improvement.

Patients frequently complain of loss of memory, dullness and lack of ability to concentrate after having been treated with shock therapy. This psychological impairment is most in evidence shortly after the completion of a treatment. Although the patient gradually recovers what appear to be his full capacities, there is good evidence to suppose that some permanent impairment is ef-

Table 3. Before Shock Treatment

No.	R	F+%	ΣC	M:C	W	D	dd	S	M	F	FM	m	K	c	FC	CF	C	C′	Cn	Rej	k	P	DW	Po
1.	39	46	25.5	0:25.5	4	27	6	2	0	17	1	3	0	1	0	0	12	2	5	0	2	0	0	1
2.	40	77	5.	0: 5.	6	22	11	1	0	24	2	0	0	9	2	1	2	0	0	0	0	2	0	0
3.	95	71	12.5	6:12.5	14	45	35	1	6	49	2	2	3	20	2	7	3	1	0	0	0	5	0	0
4.	64	57	3.0	5: 3.	6	40	16	2	5	24	7	0	0	24	0	3	0	1	0	0	0	4	0	0
5.	67	92	7.0	8: 7.	8	50	7	2	8	27	5	2	1	14	5	3	1	1	0	0	0	7	0	0
6.	15	50	0.	1: 0.	6	5	0	0	1	11	3	0	0	0	0	0	0	0	0	0	0	5	4	0
7.	57	50	3.0	3: 3.	11	44	2	0	3	20	1	1	0	21	4	1	0	0	0	0	6	5	0	0
8.	18	54	5.5	1: 5.5	10	7	0	0	1	7	4	1	0	1	0	1	3	0	0	0	0	4	1	0
9.	18	82	0.	1: 0.	2	16	0	0	1	12	0	1	0	3	0	0	0	0	0	0	1	5	0	0
10.	17	100	.5	6: .5	5	12	0	0	6	6	1	0	0	3	1	0	0	0	0	0	0	7	0	0
11.	13	92	0.	1: 0.	8	5	0	0	1	11	0	0	0	1	0	0	0	0	0	1	0	6	0	0
12.	24	64	1.5	1: 1.5	6	13	4	1	1	18	1	1	1	1	0	0	1	0	0	0	0	5	0	0
13.	31	55	4.5	6: 4.5	3	17	8	2	6	15	0	0	0	4	1	1	2	0	0	0	0	3	1	2
14.	41	71	1.5	1: 1.5	5	30	6	0	1	33	2	0	0	3	1	1	0	0	0	0	0	10	0	0
15.	5	60	0.	0: 0.	0	4	0	1	0	3	2	0	0	0	0	0	0	0	0	6	0	3	0	0
16.	13	73	0.	2: 0.	4	7	2	0	2	10	1	0	0	0	0	0	0	0	0	0	0	7	0	0
17.	9	75	0.	1: 0.	6	2	0	0	1	7	1	0	0	0	0	0	0	0	0	4	0	2	1	0
Total	566		69.5	43:69.5	104	346	97	12	43	294	33	11	5	105	16	18	24	5	5	11	9	101	7	3
%					18%	61%	7%	2%	8%	52%	6%	2%	1%	19%	3%	3%	4%	1%			2%			

Table 4. After Shock Treatment

No.	R	F+%	ΣC	M:C	W	D	dd	S	M	F	FM	m	K	c	FC	CF	C	C′	Cn	Rej	k	P	DW	Po
1.	22	81	16.5	1:16.5	1	16	5	0	1	10	1	1	0	3	3	0	1	1	9	0	0	3	0	1
2.	27	74	3.0	0: 3.	7	18	1	1	0	12	5	0	0	6	2	0	2	0	0	0	0	5	0	0
3.	14	77	2.0	3: 2.	5	8	1	0	3	4	1	0	0	2	0	2	0	2	0	0	0	3	0	0
4.	44	62	.5	4: .5	6	31	7	0	4	22	3	0	0	13	1	0	0	1	0	0	0	5	0	0
5.	34	87	0.	2: 0.	5	27	0	2	2	16	3	0	0	13	0	0	0	0	0	0	0	6	0	0
6.	12	73	0.	1: 0.	6	6	0	0	1	8	2	0	0	1	0	0	0	0	0	1	0	6	0	0
7.	40	97	4.0	2: 4.	8	30	0	2	2	12	1	0	0	13	2	3	0	0	0	0	7	6	0	0
8.	12	67	0.	0: 0.	5	7	0	0	0	10	2	0	0	0	0	0	0	0	0	1	0	3	0	0
9.	20	82	1.5	1: 1.5	3	17	0	0	1	14	1	1	0	1	1	1	0	0	0	0	0	7	0	0
10.	16	100	.5	6: .5	5	11	0	0	6	4	1	0	0	4	1	0	0	0	0	0	0	7	0	0
11.	12	80	0.	2: 0.	3	8	1	0	2	8	1	0	0	1	0	0	0	0	0	0	0	7	0	0
12.	17	87	0.	1: 0.	3	14	0	0	1	10	3	0	0	3	0	0	0	0	0	0	0	5	0	0
13.	17	77	1.0	3: 1.0	1	13	3	0	3	8	1	0	0	4	0	1	0	0	0	0	0	4	0	0
14.	16	80	.5	0: .5	1	12	3	0	0	13	0	1	0	1	1	0	0	0	0	0	0	5	0	0
15.	4	75	0.	0: 0.	0	3	0	1	0	4	0	0	0	0	0	0	0	0	0	7	0	3	0	0
16.	12	77	0.	3: 0.	2	9	1	0	3	8	1	0	0	0	0	0	0	0	0	0	0	6	0	0
17.	7	60	.5	1: .5	4	2	0	0	1	4	0	0	0	0	1	0	0	0	0	3	1	1	1	0
Total	326		30.0	30.30.0	65	232	22	6	30	167	26	3	0	65	12	7	3	4	9	12	8	82	1	1
%					20%	71%	7%	2%	9%	51%	8%	1%	0%	20%	4%	2%	1%	1%			2%	25%		

Table 5. Loss in Total Number of Responses as Related to Clinical Estimates of Improved and Unimproved

	Loss in $R \geq 10$	Loss in $R < 10$	Total
Improved	6	3	9
Unimproved	0	6	6
	6	9	15

Fisher's exact method. P=.01.

fected. Dorcus and Shaffer,[5] reporting some 10 experiments, utilizing animals and human autopsies, show that there is general agreement among experimenters that observable changes take place in the nerve tissues as a result of shock therapy. Failure to elicit evidence of deficit with psychological tests is most likely due to the character of these tests rather than to the absence of actual changes. In this connection, it is of some interest to note that where many psychological tests have failed to elicit evidences of impairment as a result of brain surgery techniques, more recently workers have obtained positive indications of impairment using the Porteus Maze type of test medium.

Statistically some doubt is cast upon the contention of earlier investigators that the Rorschach test reveals a somewhat better controlled affectivity and an improved hold on reality after insulin shock, but the clinical picture of apparent improvement remains to be explained. To what extent can the apparent clinical improvement be tied to the generally lowered capacity of the subject to make responses? Of course, as the capacity to respond is diminished, the incidence of poor responses may be decreased proportionately. Also, poorly-controlled reactions and perceptual distortions may depend to some extent on the degree of complexity of neural inter-relationships within the organism. Possibly, as a result of shock treatment, the individual reverts to a more simple and primitive type of reaction and the heightened sensitivities and highly complicated hallucinatory and delusionary symptoms become precluded because of their complexity.

Both Halpern and Piotrowski have also noted that the records of unimproved shock patients resemble the type of records found among organic patients. The resistance to treatment of patients

with organic-like records suggests the possibility that these may, in effect, represent a unique pathological entity in which the schizophrenic process is at an organic level.

Section II

The Rorschach and Wechsler-Bellevue Tests as Prognostic Aids in Insulin Treatment

Previous Test Evidence. Piotrowski[6] found that there was no significant difference in the total number of responses on the pre-treatment records of groups of patients who improved and who were unimproved. In general, the much improved groups gave longer and more elaborate pre-treatment responses, were more productive, and associated freely to the blots. Among the location responses, he noted that the W interpretations for the improved group were twice those of the unimproved group. Comparing patients who gave three or more sharply perceived W interpretations with those who gave less than three, he found that the former were significantly more frequent in the improved group. The incidence of rare details was somewhat lower in the improved group. Piotrowski also found that patients who improved later gave five times as many M interpretations as the others and that unimproved patients gave vaguely perceived M—. The F+% of the improved group was reported as considerably higher than the unimproved group. Concerning the affective picture, a marked increase was noted in the number of color responses, and there was a generally lower *Erlebnistypus* in the unimproved group. Piotrowski,[6] in more recent articles, has presented less formalized, although probably more critical, prognostic criteria. It was felt, however, that signs based on suggestions from his earliest paper would be most amenable to further testing. Halpern[1] reported that improved patients showed a greater productivity, a better *Erlebnistypus,* and the presence of more human responses in their pre-treatment records. The number of movement responses, both animate and inanimate, was reported as five times greater in the improved group. Bolles, Rosen and Landis,[7] utilizing the Vigotsky test, the Weigl test and the BRL Sorting test, demonstrated that performance on these tests was related to the capacity for improvement with insulin shock therapy. They found that patients who gave the most superior results on these tests of

abstract intelligence showed the greatest amount of improvement during insulin therapy. Carp[2] demonstrated that improvement under insulin was noted only in those cases where the patient was at least of average intelligence. No improvement was noted among patients with I. Q.'s of less than 90.

A Sign Approach to Prognosis. Based on suggestions from previous test evidence in the literature, a list of positive and negative prognostic signs was developed *a priori* and applied to the test data on the 17 paranoid schizophrenic patients of the present experiment. Signs were scored without knowing which patients were rated as improved and unimproved by the psychiatrists—to maximize the objectivity of the ratings. Two of the 17 patients were placed in a doubtful category by the psychiatrists. These two cases were omitted from the statistical evaluation so that only those cases were included where the improvement or lack of improvement was clearly established.

The following signs were scored for each subject.

Weights	
Positive signs	
+1	1. Productivity. More than 25 responses, or highly elaborated responses.
+2	2. A color sum of 2.5 or greater.
+2	3. An F+% of 70 or greater.
+1	4. The presence of one or more good human movement responses.
+1	5. The presence of three or more sharply perceived W responses.
Negative signs	
−1	1. An I. Q. on the Wechsler-Bellevue of less than 90.
−1	2. Three or more rejections.

A weighted "sign" score of 3 was arbitrarily chosen as a critical point.

Table 6. The "Prognostic Sign Score" as Related to Clinical Estimates of Improved and Unimproved

	Weighted sign score ≥ 3	Weighted sign score < 3	Total
Improved	8	1	9
Unimproved	2	4	6
	10	5	15

Fisher's exact method. P=.05.

Weights of 2 were given to the F+% and Color Sum signs because of the importance given these factors by previous investigators.

Of the nine cases in which there was a definite indication of improvement after treatment, only one would have received a poor prognosis, utilizing this sign approach, and of the six patients diagnosed as unimproved after treatment, only two would have had favorable prognoses. The results in general suggest that the test signs employed here to estimate prognosis under insulin shock therapy are valuable assets to the clinician who must sort patients for various types of therapy; but they are not presented as a replacement or short cut for the more thoroughly reliable method of complete individual record analysis.

Conclusions

1. Carp's finding that there is no significant increase in I. Q. scores as a result of insulin treatment is confirmed. Since Carp's data was unavailable to the author except in abstract form, it is impossible to comment on Carp's finding that there was no change in Rorschach protocols pre- and post-treatment.

2. There are suggestions of improvement in the reality level of perception and affective control as a result, presumably, of insulin shock treatment but the change is not statistically significant.

3. Clinical ratings of improvement between the pre- and post-Rorschach records, as a result of insulin shock therapy, are most closely related to the loss in total number of responses.

4. The relationship between loss in ability to respond and improvement suggests that insulin possibly effects improvement by means of impairment. It is suggested that impairment might serve to desensitize the organism and to preclude complex reactions. The organism is thought of as returning to a more primitive level of adjustment.

5. A series of signs culled from the literature and applied *a priori* to the Rorschach records of 15 paranoid schizophrenic patients without knowledge of psychiatrists' ratings proved to be of value in making prognostic estimates of improvement under insulin shock therapy.

Brooklyn State Hospital
Brooklyn, N. Y.

REFERENCES

1. Halpern, F.: Rorschach interpretation of the personality-structure of schizophrenics who benefit from insulin therapy. PSYCHIAT. QUART., 14:4, October 1940.
2. Carp, A.: Psychological test performance and insulin shock therapy. In: Abstracts of dissertations, 1947-1948 (Stanford University Bulletin, 8:19, 180-183, 1948. Abstract of Ph.D. thesis, 1948).
3. Hales, W., and Simon, W.: Minnesota Multiphasic Personality Inventory patterns before and after insulin shock therapy. Am. J. Psychiat., 105:254-258, 1948.
4. Derner, Gordon F.; Aborn, Murray; and Canter, Aaron H.: The reliability of the Wechsler-Bellevue subtests and scales. J. Clin. Psychol., 14, in press, June 1950.
5. Doreus, R. M., and Shaffer, G. W.: Treatment by physical and chemical assault. In: Textbook of Abnormal Psychology. Williams & Wilkins. Baltimore. 1945.
6. Piotrowski, Z. A.: The prognostic possibilities of the Rorschach method in insulin treatment. PSYCHIAT. QUART., 12:4, October 1938.

——: Rorschach manifestations of improvement in insulin-treated schizophrenics. Psychosom. Med., 1:508-526, 1939.

——: A simple experimental device for the prediction of outcome of insulin treatment in schizophrenia. PSYCHIAT. QUART., 14:2, 267-273, April 1940.

7. Bolles, M. M.; Rosen, G. P.; and Landis, C.: Psychological performance tests as prognostic agents for the efficacy of insulin therapy in schizophrenia. PSYCHIAT. QUART., 12:4, 733, October 1938.
8. Malzberg, B.: Outcome of insulin treatment of 1,000 patients with dementia præcox. PSYCHIAT QUART., 12:3, 528, July 1938.
9. Sakel, M.: Pharmacological shock treatment of schizophrenia. P. 136 ff. Nerv. and Ment. Dis. Publishing Co. New York. 1938.

JUVENILE AMAUROTIC FAMILY IDIOCY: FEATURES SUGGESTIVE OF PRECOCIOUS SENILITY*

BY REUBEN M. CARES, M. D.

The infrequency of published cases of the juvenile form of amaurotic family idiocy is noteworthy, both in this country and abroad. There are four forms of amaurotic idiocy, a heredodegenerative disease, the familiar infantile type of Tay-Sachs; a late infantile type; a juvenile type; and an adult form. Only four cases of the juvenile type with clinico-pathological data have been reported to date[1, 2, 3, 4] in this country, two of them from mental hospitals in New York State. This form has been designated as the Vogt-Spielmeyer type following descriptions by these authors respectively in 1906 and 1908.[5, 6] However, the earliest mention of this post-infantile variant of amaurotic idiocy had been made by Batten[7] in 1903. He first described the disease as resembling the Tay-Sachs form but differing in that it occurred in non-Jewish patients and was not associated with the distinctive cherry-red macular spots in the eyes.

In reporting an additional case, the pathogenesis of this inevitably fatal disease may be made less obscure. It must be emphasized that this disease has constant and striking criteria of idiocy, convulsive state and increasing blindness with retinitis pigmentosa. Early diagnosis of potential cases at large would encourage extended clinical and laboratory studies since the disease, while progressively severer, runs a course of from six to as much as sixteen years. The etiology of the disease, in common with the other forms, is currently based on association with abnormal lipoid accumulations in the neurons throughout the body. The present case presents clinical and histological features so analagous to those found in primary senile dementia as to justify consideration of a related etiology.

Case Report

In September 1941 Richard G., a white boy, an only child, born in Peekskill, N. Y., was first observed as having suffered a loss of vision. He was five years and one month old. He was fitted with

*Preliminary draft of this paper presented at the Spring 1950 Interhospital Conference at the New York State Psychiatric Institute by Reuben M. Cares, M. D., and Pompeo Milici, M. D.

glasses six months later with only temporary relief. When stronger glasses failed to help, the Manhattan Eye and Ear Clinic referred him to the Vanderbilt Clinic, from where, on November 2, 1942, he was admitted to the Neurological Institute, which noted the following data.

Family History. The father's mother and sister and his mother's father were said to have recovered from mental illnesses.

Personal History. The child's birth and early development were normal. He had been inoculated against diphtheria at six months and vaccinated at four years. Five months after admission to the Neurological Institute, he was regarded as somewhat above average in general intelligence. His vocabulary was excellent, and he used words well. He remained very disturbed by the steady loss of his sight. At the age of six and a half, he could detect light only when directed into his eyes. The blood count, blood chemistry, Kline test, spinal fluid examination and skull x-ray were negative. A 16-lead EEG with monopolar and bipolar recording showed bilateral phase-reversal over the occipital and parietal areas. Opening and closing the eyes had no marked effect on the rare alpha waves. The impression was that of an abnormal EEG. On ophthalmological examination, there were no hemorrhages or exudates. The pigmentary disturbance, optic atrophy and markedly-narrowed arterioles, aroused suspicion of a familial degenerative process. It was felt that this was an atypical case of retinitis pigmentosa. On November 12, 1942 he was discharged.

Richard was admitted to the New York Institute for the Education of the Blind in January 1943. At the age of seven in March 1943, he scored an I. Q. of 89. Charming and lovable, he won affection, but he could not adjust to group activities. His attention was difficult to hold, he could not remember routine, and he did not stick long to assignments. He did not learn to dress himself or to get to bed without help. He did not progress in any of the kindergarten work; he could not learn much phonetic reading or many Braille letters, or gain much understanding of word building. He seemed to enjoy listening to stories, but it was questionable how much meaning these had for him. In arithmetic he learned a few combinations but he could not apply them in everyday life. He could weave, punch patterns and paste under close supervision but not independently, even after he had been exposed to these activities for over two years.

Richard enjoyed handling clay but did very little constructive work with it. In the classroom, the boy was rarely included in any games but amused himself with clay, toys and beads. On the playground, he played alone in the bushes, rode his scooter, or sought the companionship of the adult on duty. He enjoyed the out-of-doors and had an intense interest in animals and in growing things. When he did not feel well, he created disturbances, interrupted classes by talking, pounded his hands, stamped his feet and started quarrels. Often he seemed to be fearful, and he would tremble violently when confronted with unfamiliar situations. At night he talked of animals chasing him and getting into his bed, and he would wander around the halls, rapping on doors. On several occasions, care at home for a few weeks brought about brief improvement in behavior.

A Hayes-Binet test in November 1944 (C. A., eight years four months) yielded a mental age of five years six months and an I. Q. of 66. Richard could repeat only three digits forward and could not repeat a simple sentence without error. In December 1944 each eye had vision of 2/200 with the field contracted to 10 degrees. An examination performed in early January 1945 described him as follows: "He is struggling to overcome a sense of inadequacy and in this effort he evokes aggression and a rather non-conformist attitude. He is intelligent and, to a certain extent, above his educational bracket. Conduct, choice of words and ideological content disprove the presence of any intellectual handicap. On the other hand he indicates the presence of forceful emotional blocking and discord. He feels insecure, rootless and unwanted. To escape from this predicament he even wanted to change his name." His condition was looked upon as a psychoneurosis, characterized by anxiety states and a trend to detachment from reality. However, note was made of diffuse, persistent headache and another EEG was recommended.

Following 10 days in the infirmary with chickenpox in January 1945, the boy was markedly overactive. He threatened and assaulted other children, took their food, loudly demanding large quantities for himself, constantly asked for pills and nose drops, sat in the washroom bowl and threw soap. At night he made peculiar noises.

In May 1945 a second EEG (6-lead), with monopolar recording, yielded an irregular, and at times, disorganized record. With hy-

perventilation there was a markedly abnormal response, consisting of long runs and of synchronous bursts of high activity. The impression was that of an abnormal record consistent with, but not diagnostic of, convulsive disorder.

Placed on sodium dilantin and glutamic acid, the patient showed brief improvement in behavior. Soon again, quivering and tense, he made queer noises, screamed, stamped his feet, tore papers to bits, pounded on lockers, bit piano legs, tried to tip over tables on which other children were working, and was assaultive.

Discharged from the New York Institute for the Blind in June 1945, and almost nine years old, Richard adjusted fairly well at home for about a month and then again became increasingly difficult to manage. Complaining often of severe headache, he refused medicine and food, cried, screamed and cursed, jumped about and ran around, stamped his feet, slammed doors and was destructive and assaultive. He spent increasing time in bed. At night he was particularly upset and was insistent upon having a member of the family near by.

In January 1946 the patient was admitted to Bellevue Hospital. There he was described as well developed and generally healthy except for bilateral blindness with retinitis pigmentosa. A skull x-ray, Wassermann and neurological examination were all negative. His behavior was like that of an acute anxiety reaction to blindness, but note was made of the progressive course of the disorder, and psychosis with organic brain disease was diagnosed.

Richard was admitted to Kings Park State Hospital on January 30, 1946 aged nine and a half. The physical examination revealed nothing new. Depressed and apprehensive, the boy stated that medicine no longer helped his headaches and that sometimes at night he heard voices coming from his heart, which talked and whispered to him and made animal-like sounds which frightened him. While he was well enough behaved to attend school, attempts were made to instruct him in Braille. At night, however, it was difficult to keep him in bed, and he screamed often, wanting someone near him.

At diagnostic staff meeting in March 1946 he was classified as follows: psychosis with other somatic disease; retinitis pigmentosa: blindness: behavior disorder. In April 1946 the eye consultant confirmed the eye finding of retinitis pigmentosa. In June 1946 the boy made an uneventful recovery from measles. In

August 1946 he was placed on convalescent care, and his parents reported that he was much improved.

The boy was returned to the hospital in February 1947 after five weeks of difficult behavior. It was apparent that he had gone down hill. Fearful and irritable and often disturbed, he slept poorly, talked of seeing animals, fought off medication, scratched himself and assaulted others.

At this time, at the age of 11, he showed increasing asthenia and loss of weight, and he had to stay in bed much of the time. He wet, soiled himself and smeared feces. A month later, the eye consultant diagnosed bilateral optic atrophy, possibly congenital. In July 1947 an x-ray revealed a moderate liver enlargement.

The following year, on December 8, 1949 his temperature rose to 106. The x-ray indicated a pneumonic process in the left lung. He died the following day at the age of 13 years four months, in an emaciated condition.

Pathological Findings

Gross

An autopsy performed seven hours after death, with the clinical history in mind, revealed a hemorrhagic bronchopneumonia, toxic purpura of legs and arms, and mild cerebral edema.

The brain was normal in size, shape and symmetry. Mild cerebral surface congestion of the finer vessels and slight clear edema of the pia-arachnoid were seen. Only the frontal lobes presented deeper than normal sulci, but the grey matter, here as elsewhere, was of normal width and appearance. The cerebellum and brain stem showed no atrophy.

Microscopic

Technique. Appropriate blocks of tissue from all parts of the central and autonomic nervous system, in four fixatives, were subjected to routine stains for nervous tissue for Nissl bodies, neurofibrils, glia, myelin and mesenchymal elements. Stains for lipoids and pigments were also used.

As preliminary sections disclosed the presence of widespread granule deposits in the neurons, additional specific techniques for staining of fatty substances—Ciaccio, Sudan III, and Scarlet R methods—were applied to paraffin sections as well as to frozen sections. Thus the solubility of the lipoids of the tissue passing

through common fat solvents—alcohol, acetone, chloroform, xylol, ether and benzene—was tested. As emphasized by previous workers, particularly Jervis, Roizin and English,[3] the lipoid granules strongly resisted solubility in all fat solvents in the cold state (Figure 1). Only prolonged immersion—over two hours in hot (60° C.) chloroform, benzene, and absolute alcohol or mixtures of these—effected a negative staining in Sudan III. The paraffin-sectioned tissue immersed in acetone at 60° C. required 12 hours to dissolve the sudanophil granules. These lipoid pigment granules were further studied by polarized light and showed no double-refraction. Under the fluorescence microscope these granules showed a brown fluorescence, strikingly similar to lipofuscin pigment such as found in neurons of senile brains.

Histopathology

General neurological staining, using myelin stains, the Globus-Cajal gold stain, confirmed the color reactions previously noted. The most constant and ubiquitous feature was the intracytoplasmic deposits of fine granules in the neurons. These were involved in all parts of cortical and subcortical gray matter of the central nervous system. No part of the cerebrum, cerebellum, basal ganglia, pons and medulla was entirely free of neuronal deposits. A quantitative variation in the deposits of the cytoplasmic granules was noted in many zones. The morphology of the ganglion cell changes by the deposits conformed to reported descriptions of the swollen or distorted cells.[3, 8, 9]

The cytoarchitecture of the cerebral cortex was universally distorted, with loss of cells and laminations most marked in the frontal lobes and becoming uniformly milder toward the occipital poles. Of the various layers, the fifth layer most often showed severest loss or shrinkage of the nerve cells. In the cortex of the frontal lobe, this layer showed practically completed end-stages of shrunken cells or even entire absence in a number of fields.

The Purkinje cells of the cerebellum revealed a very marked range in the degree of deposits and cell degeneration. There was a small percentage of well-preserved neurons with scanty deposits. All recorded changes from massive deposits in the cell body and the main dendrites to final stages of shrunken and distorted cell bodies were observed. All the other features in previous studies —disappearance of the Purkinje cells, decreased fiber reticulum,

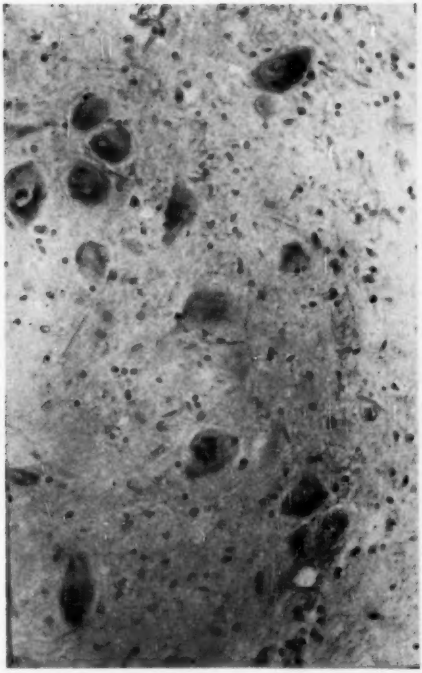


Fig. 1. Neurons containing large discrete granules. Paraffin sections pretreated with warm acetone before Sudan IV Stain. X 250.

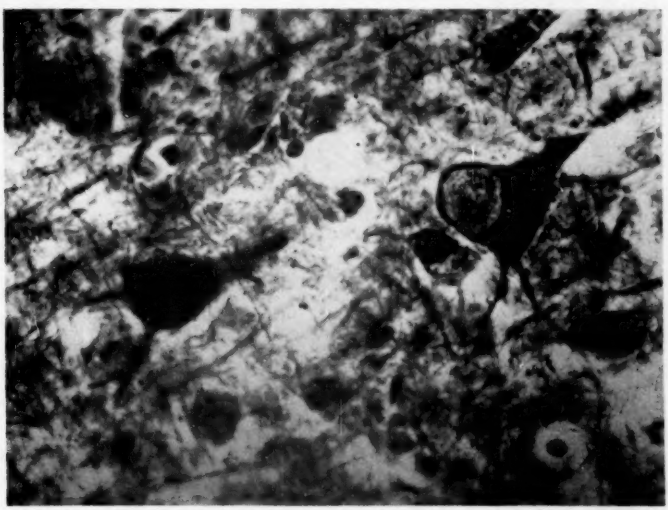


Fig. 2. Two neurons from the parietal cortex. Eccentrically placed sac of granules in cell on right. Bielschowsky Stain. X 500.

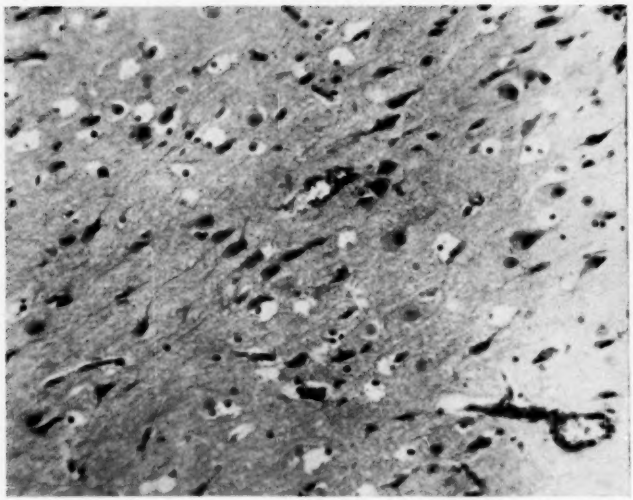


Fig. 3. Group of neurons showing atrophy. Eccentric pyknotic nuclei and rusiform cell bodies. So-called mulberry body changes of surrounding glia cells. Shorr Trichrome Stain. X 125.

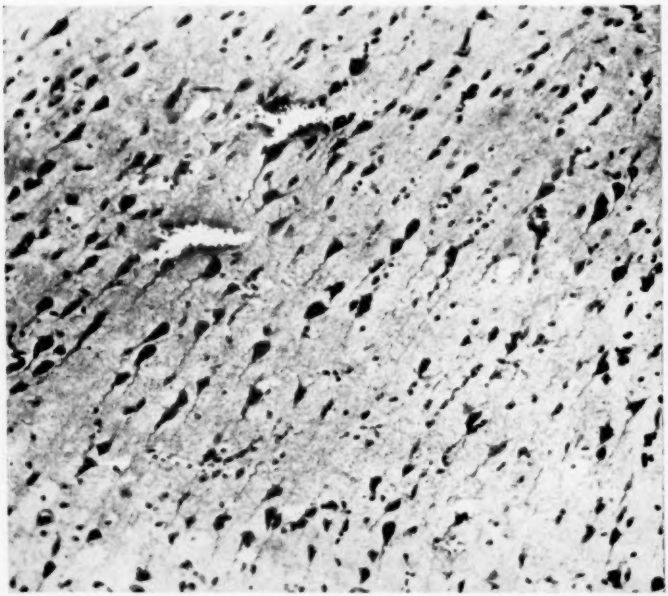


Fig. 4. Frontal lobe cortex. Broad fields of chronic neuron disease with corkscrew apical processes. No glial alteration. Shorr Trichrome Stain. X 125.

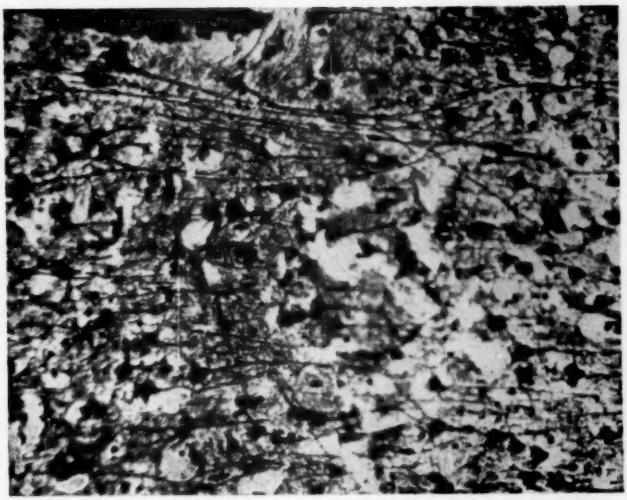


Fig. 5. Frontal lobe cortex. Bielschowsky Stain showing atrophic neurons with decreased dendrites and considerably elongated apical processes. Granule content not excessive. X 125.

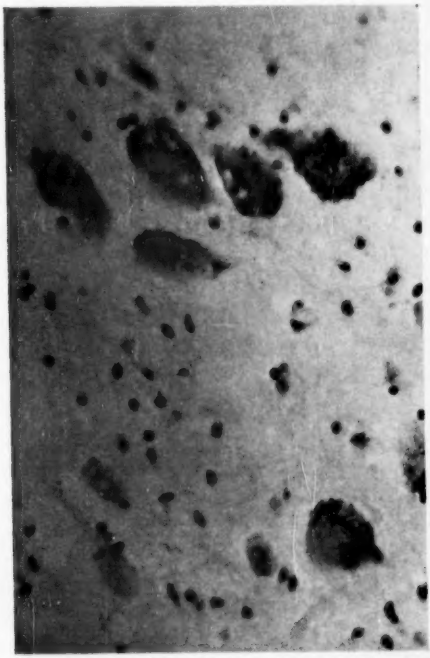


Fig 6. Nest of neurons from pontile nucleus. The perinuclear granule deposits have displaced dark-staining Nissl substance to the rim of cells. Nuclei fairly preserved. Cresyl Violet Stain. X 400.

a thinned granular layer—were noted, as copiously illustrated in the comprehensive paper by Globus.[4]

Changes in the myelin sheaths, glia, meninges and blood were neither striking nor universal. Findings in the main agreed with those of previous writers,[3, 4, 5, 6] with differences restricted to quantitative factors. Demyelinization was mild, spotty and subcortical in nature. It appeared dependent on the severity of contiguous nerve cell damage or disappearance. In a very few perivascular spaces of the centrum semiovale, fatty substances of normal solubility in fat solvents were stained by Sudan III.

The glia cells were slightly increased in number and size in a few zones of the frontal and temporal lobes. The presence of foamy astrocytes or mulberry cells[4] was most noticeable in the deeper cortex and especially in the lenticular nucleus and claustrum as emphasized by Dide and Bogaert.[10] No significant increase in glial fibers was found using the Holzer and phosphotungstic-acid stains. All blood vessels, both small and large, were normal in structure and caliber. The meninges were thin and relatively acellular with focal mild edema of some intergyral folds.

Sections from the viscera disclosed, in all ganglia, identical granule accumulations of varying degree in the neurons of the adrenals, intestines, pancreas, and posterior hypophysis.

When attention was turned from the arrangement and distribution of the granules, equally striking and massive degenerative changes in the cortical neurons and their patterns were seen. First, the better preserved neurons, as found in the parietal and occipital lobes, the basal ganglia and hindbrain, in spite of moderate or even large amounts of granule deposits revealed well-stained neurofibrils (Figure 2) and adequate amounts of Nissl substance. Second, as the nerve cells advanced to the end-stages of shrinkage and pyknosis, there was a proportionate decrease in the amount of granule deposits (Figure 3). In the final stages a small pyknotic nerve cell of pyriform outline and with corkscrew apical dendrite was very common with a minimal content of granules (Figures 4 and 5). Such terminal widespread changes were mainly in the frontal lobes.

With Nissl stains, many areas of the frontal cortex, as well as occasional gyral foci in the temporal and parietal lobes, presented a pattern quite similar to that of senile cortical degeneration. The deep, structureless neuronal staining appeared with other aniline

dye stains. Nissl substance was fused and decreased in amount (Figure 6). Cell sclerosis was present, and in many such cells the granules were absent, as if it were no longer necessary to damage these cells. With Bielschowsky stain, these areas of ganglion cell atrophy again presented a picture reminiscent of senile dementia, with thick markedly-elongated apical processes, as seen in Figure 3. A wide search for the argyrophil senile plaques of senile or presenile dementia was negative. No distinctive baskets or coils of Alzheimer's neurofibrillary changes were found. The intracellular neurofibrils were thickened or fused, generally straight. The changes were essentially of simple cell sclerosis in various stages of completion, and associated with granule deposits suggestive of lipofuscin or lipochrome pigment which stigmatize such neurons commonly in senile dementia.

Discussion

The Nature of the Cell Granules

Some cases of Niemann-Pick's disease, which is accepted as a lipoid histiocytosis, present clinical and pathological features of Tay-Sachs' disease. Since the former disease is one of lipoid metabolism dysfunction, many workers have accordingly assigned all four forms of amaurotic family idiocy, from the infantile to the adult type, to the category of lipoid dysmetabolism. The lipoid granules of the juvenile form are, however, admitted to be somewhat different from those of Tay-Sachs' disease in histochemical properties by Bielschowsky[11] and Globus.[9] In addition, Hurst[12] made an exhaustive chemical study in three cases of amaurotic idiocy, one of the juvenile type. He claimed that the differences in the chemical nature were inherent in the disease process. The writer agrees with his conclusion that the neuronal granules in the juvenile form show a close resemblance to the lipochromes in chronic neuronal degenerations of senility.

The uncertainty of the lipoid nature of the granules may be seen in the equivocal terms used. Klenk[13] considered them to be a form of silver protein, Shaffer[14] and Globus[4] term them prelipids while others have identified the granules as related to sphingomyelin. Attempts to reproduce the disease by injections of sphingomyelin in monkeys and rabbits were made in 1940 at the New York State Psychiatric Institute. General visceral changes similar to the Niemann-Pick changes were readily produced, but no changes were

observed in the central nervous system.[15] In the present case, the writer's cytological studies revealed staining reactions quite similar to lipochrome pigment. This, plus the findings of brownish fluorescence, confirms the similarity to lipofuscin senile pigment as maintained by Hurst in 1925. The largest group of pathological studies of the juvenile form, 19 autopsied cases, was reported from the National Institute for Blind Children in Sweden by Sjovall and Ericsson.[16] These authors also considered the granules to be lipoids similar to those found in senile brains. The writer is firmly in agreement with their conclusions that the lipoids are not responsible for the destruction of the cell, but may be an indication of the stage of neuronal involution.

The Senescent Neuronal Process

The neuronal changes of nuclear pyknosis, cell shrinkage, loss of processes, disappearance of Nissl substance and the pronounced corkscrew transformation of the apical processes as described in the foregoing are all reminiscent of the histopathology of senility. The complete lack of inflammatory, or the common vascular, factors of later life is noteworthy. As in senile dementia, the writer found the severest changes in the frontal lobe cortex in his case. Sjogren, at the Swedish Institute, reported, in a lengthy monograph, on 39 juvenile cases that he had studied over many years from a clinical viewpoint.[17] He emphasized the features of stiff posture, ataxia and the end stages of bed-wetting and cachexia. Recently, juvenile amaurotic idiocy was reported[18] in a 17-year-old Brazilian boy of Portuguese extraction. This case was clinically regarded as Wilson's disease with a presenile picture. Autopsy revealed the unexpected neuronal changes of amaurotic idiocy, both in the cortex and basal ganglia.

As in senile dementia not attributable to arteriosclerosis, the visceral and mesodermal structures throughout the body are not affected in juvenile amaurotic idiocy. The involvement of ganglion cells in the sympathetic ganglia indicates a universal affection of neuro-ectoderm regardless of location. The very comprehensive studies of the Swedish workers, Sjogren clinically, and Sjovall and Ericsson on the pathology, must bear considerable weight. The latter authors termed the disease "senium precox." The writer's similar thought was arrived at independently on the first perusal of the drastic cortical neuronal atrophy in "the seat of judgment"

—the frontal lobes. The granules or pigment may be an indication of idiopathic senescence of nerve cells. The progressive increase in pigment deposits in the aging neuron follows or accompanies nerve cell regression. Sachs is quoted by Globus[4] as stating as early as 1905 that "the author still firmly believes that amaurotic family idiocy is due to an arrest of development, and that this arrest is followed by degeneration." This "degeneration" here is stigmatized by precocious deposition of lipofuscin pigment in the doomed neurons in childhood. This same pigment when noted in neurons in late life, is universally accepted as a stigma of senility.

Other considerations of the pathogenesis of amaurotic family idiocy have been amply discussed.[4] The concern has been more with the nature of the initiating disturbance and less with the clinical picture arising from the premature failure of neuronal functioning. Thus, a congenital origin of the process has been advanced.[19] The disturbed metabolism manifested by large cell deposits of lipopigment granules is variously based on enzyme deficiency,[20] endocrine imbalance[21] or a selective deficiency of the neuro-ectodermal germ layer.[22] With regard to the basis of the blindness, as Hassin emphasizes,[23] the ganglion cell degeneration is identical with that in the brain. He agrees with Sachs[24] that an abiotrophy or agenesis best describes the underlying mechanism. Regardless of the means, the end-product consists of worn-out, or physiologically old or senile, nerve cells. Thus the symptomatology should and does approximate that which is associated with the aging brain of late life.

The writer is aware that corollary findings in the senile brain of neurofibrillary degenerations and senile plaques are absent in juvenile amaurotic idiocy. Arteriosclerosis also plays no significant role, although on occasion some thickening of the media of small arteries has been described.[3] Both the neurofibrillary and vascular alterations are frequent phenomena of senility along with neuronal cell sclerosis or shrinkage. They can and do occur in variable intensity and are presumably independent, even when concurrent.

Neuropsychiatric Significance

Clinical diagnosis of the Tay-Sachs form of amaurotic family idiocy can generally be made early. This is not difficult because of the pathognomonic cherry-red spot observed whenever eye ex-

amination is made. In juvenile amaurotic idiocy, there is no reason why diagnosis should not be established early also. Instead of the macular degeneration there is a striking constancy of retinitis pigmentosa. The triad of eye changes, progressive idiocy and a convulsive disorder is a sufficiently unique combination to enable quick recognition of this disease in spite of its rarity. Unfortunately, most studies of the juvenile form are confined to pathological aspects. The long duration in years of the affection before inevitable fatality provides a promising opportunity for the neurologist or psychiatrist. He has considerable time to throw light on the physiological mechanisms involved in amaurotic idiocy.

Future cases should be subjected to long-term laboratory tests of metabolic nature coupled with psychometric and psychoanalytic observations. Emphasis could be placed on comparative analysis with senile dementias. Juvenile amaurotic idiocy can be viewed as a pure form of senile dementia, completely divorced from the overlapping influences encountered in the senile patient. These are cardiovascular degenerative diseases, senile plaques, or systemic influences on the brain. All of these interfering factors will tend to modify or obscure the primary process affecting the neurons. The field of experimental neurology, in spite of its wide application, has hitherto been unable to reproduce in animals a valid picture of accelerated senility of the nervous tissues.

Juvenile amaurotic family idiocy should show promise in throwing light on the phenomenon of senile dementia. The great handicaps of concomitant vascular, endocrine and nutritional deficiencies that are usually present in the late decades of life are excluded in studying the precocious senile process seen in juvenile amaurotic idiocy.

Summary

A clinical and pathological study of juvenile amaurotic idiocy is presented with an illustrative case report. The case described had the classical criteria of retinitis pigmentosa, progressive mental deterioration and a convulsive component as evidenced by the electro-encephalogram.

Pathological and histochemical studies indicate pigmentary and neuronal changes similar to those associated with alterations of the senile brain. The neuronal deposits are of a lipochrome na-

ture, similar to, if not identical with, lipofuscin. The concept of a precocious senility is advanced to stimulate comparative studies with the dementias of senility.

It is pointed out that, regardless of the etiology—either of lipoid disorder, congenital deficiency of the neuro-ectodermal germ layer, or arrested physiological maturity of the nerve cells—a final clinicopathological state of senility is reached in the nervous system of juvenile amaurotic family idiocy.

ACKNOWLEDGMENT

The writer is indebted to Dr. Pompeo Milici for the abstract of the clinical chart.

Clinical Laboratories
Kings Park State Hospital
Kings Park, N. Y.

REFERENCES

1. Fitz Jerrel, H. B., and Neuchiller, B. B.: Amaurotic family idiocy (juvenile form). Illinois Med. J., 74:456-461, 1938.
2. Jervis, G. A.: Juvenile amaurotic family idiocy. Am. J. Dis. Child., 58:327-338, February 1941.
3. Jervis, G. A.; Roizin, L.; and English, W. H.: Juvenile amaurotic idiocy, PSYCHIAT. QUART., 16:1, 132-143, January 1942.
4. Globus, J. H.: Amaurotic family idiocy. J. Mt. Sinai Hosp., 9:4, November 1942.
5. Vogt, H.: Über familiare amaurotische Idiotie und verwandte Krankheitsbilder. Monat. f. Psychiatrie u. Neurologie, 18:161-168, 1906.
6. Spielmeyer, W.: Klinische und anatomische untersuchungen über eine besondere Form von familiarer amaurotischer Idiotie. In: Histologische Arbeiten über die Grosshirnrinde—F. Nissl, 2, 1908. G. Fisher. Jena.
7. Batten, E. E.: Cerebral degeneration with symmetrical changes in the macula. Trans. Ophthal. Soc., 23:390-395, 1903.
8. Globus, J. H.: Ein Beitrag zur Histopathologie der Amaurotischen Idiotie. Zeit. f. d. ges. Neurologie u. Psychiatrie, 85:424-434, 1923.
9. Globus, J. H.: Amaurotic family idiocy. In: Cytology and Cellular Pathology of the Nervous System. W. Penfield, editor. Hoeber. New York. 3:1166-1182, 1932.
10. Dide, M., and Bogaert, L. V.: Sur l'idiotie amaurotique juvenile. Rev. Neurol., 69:1-42, January 1938.
11. Bielschowsky, M.: Histopathology of nerve cells. Cytopathology and Cellular Pathology of the Nervous System. W. Penfield, editor. Hoeber. New York. 1:178, 1932.
12. Hurst, E. W.: A study of the lipoids in neuron degeneration and in amaurotic family idiocy. Brain, 48:1-42, March 1925.

13. Klenk, E.: Beitrage zur Chemie der Lipoidosen Niemann-Picksche Krankheit und Amaurotische Idiotie. Zeit. f. Physiologische Chemistrie, 262:128-148, 1939.

14. Schaffer, C.: Pathogenesis of amaurotic idiocy. Arch. Neurol. and Psychiat., 24: 765-774, October 1930.

15. Ferraro, A., and Jervis, G. A.: Studies in experimental lipoidoses. Arch. Pathol., 31:731-744, September 1940.

16. Sjoval, E., and Ericsson, E.: The anatomical type of the Swedish cases of juvenile amaurotic idiocy. Acta pathologica et microbiologica Scandinaviske, 16:460-471, 1933.

17. Sjogren, T.: Die juvenile amaurotic Idiotie. Hereditas, 14:197-425, 1931.

18. Marques, A.: Dystonic form of amaurotic family idiocy. Arch. Neurol. and Psychiat., 58:46-56, July 1947.

19. Norman, R. M., and Wood, N.: A congenital form of amaurotic family idiocy. J. Neurol. and Psychiat., 4 (new series): 175-184, 1941.

20. Marinesco, C.: Nouvelles reserches sur la forme de Spielmeyer-Vogt de l'idiotie amaurotique et son mechanisme biochemique. Encéphale, 22:605-615, 1927.

21. Marburg, O.: Studies on the pathology and pathogenesis of amaurotic family idiocy. Am. J. Ment. Def., 46:312, 1942.

22. Schaffer, C.: Pathogenesis of amaurotic family idiocy. Arch. Neurol. and Psychiat., 24:765, October 1930.

23. Hassin, G. P.: Histopathologic observations on the changes of the eyes in a case of amaurotic family idiocy. J. Mt. Sinai Hosp., 9:4, 536-544, November 1942.

24. Sachs, B.: On amaurotic family idiocy, a disease chiefly of the gray matter. J. N. M. D., 30:1-19, 1905.

PSYCHOPATHOLOGY OF PERSONALITY FUNCTIONS IN PSYCHOPATHIC PERSONALITIES*

BY F. A. FREYHAN, M. D.

The various phases of formulation and re-formulation through which the concept of psychopathic personality has passed, reflect most vividly the developmental trends of psychiatry during the first half of our century. While controversies have been abundant, there has never been any serious doubt regarding the essentiality and validity of a concept that deals with the personalities who differ characterologically from the average population, but are not covered, in terms of psychiatric personality analysis, by criteria established for neurotic and potentially psychotic individuals.

Psychopathic personalities differ from other people in their way of human existence: (1) in the manner in which they experience themselves and their stations in life, (2) in the manner in which they impress people through their social behavior.

We are here not concerned with recitation and appraisal of the various formulations pertaining to these personalities, but rather with the fact that the current use of the term psychopathic personality constitutes what seems to be an unnecessarily controversial issue. It is, on the one hand, not difficult to understand that the multiplicity of characterological aspects of these personalities has been a traditional obstacle to a simple clinical arrangement. On the other hand, the following question presents itself: Can a greater measure of agreement be reached with respect to the criteria to be applied and the limitations to be placed on the use of the term, psychopathic personality? There is, the writer believes, evidence to the effect that this aim could be accomplished if (1) we recognize and eliminate a number of conceptual obstacles, and (2) direct our attention toward certain main aspects of personality functions and dysfunctions which can substantially contribute to our understanding of the psychopathology of these personalities.

Conceptual obstacles must be seen in selective viewpoints, which according to rigid orientations, deal with either the biological, the

*Presented at the 106th annual meeting of the American Psychiatric Association in Detroit, May 2, 1950.

sociological, or the psychological manifestations of personality. Here must be included tendencies to rely primarily on demonstrable pathophysiological signs, of which electro-encephalographic tracings have attracted the main attention during recent years. Here belong the attempts to single out the sociopathic elements in psychopathic behavior which have constricted the application of the concept to the so-called antisocial personalities. A purely sociological evaluation of behavior, however, does not promote deeper understanding of the relationship of individual motivation and individual personality functions, a relationship which alone would seem to provide the basis for psychiatric characterology. Moreover, the subject of social conformity has quite different connotations for different judges of human behavior and a great deal of subjectivism enters into evaluations which depend so predominantly on the social philosophy of the judging person. Dissatisfaction with a state of society, i. e., maladjustment, has often worked as a catalytical agent for religious, social and philosophical movements of historical consequence. Again, other obstacles have been created in the form of certain clinical typologies, based on penetrating observations of outstanding psychological characteristics, but having the disadvantage of all typologies: of not portraying the individual aspects in a given instance. And obstacles must also be recognized in purely intellectualistic efforts to interpret the complex issue of individual motivation in terms of generalizing psychodynamic formulas, which reduce the wide variety of characterological phenomena to a simple question of relative dominance of unconscious forces.

Such conceptual obstacles have in common the danger of producing cliché-formulations at the expense of the dynamic aspects of individual reality. The psychiatrist is, of necessity, more interested in the individual than the generic aspects of personality. A comprehensive understanding of motivation depends not so much on what people have in common as on what is unique in them. Our understanding of individuality may be more apparent than real, however, if we fail to appraise the uniqueness of the individual in terms of concrete components of individuality which influence every fragment of behavior. Not too many years ago, human blood was thought to be of identical composition. Today we know an ever-increasing number of individual blood components and have replaced the concept of a species plasma with that of indi-

vidual plasmas. If we conceive of the individual, following the formulation of Leo Loeb, as a mosaic of many tissues and organs, each one functioning in its own peculiar way, we may consider this mosaic of separate parts as the biological basis of individuality. There are additional properties which are not restricted to certain parts of the organism but which bind them together, make them into a unit and differentiate one individual from every other individual. These particular characteristics, inherent in every higher individual organism, are designated as his individuality differentials. Physiologically the individual remains bound up with his organism, and the needs and functions of the latter direct and influence his behavior. Individuality-differentials which determine specificity of tissue reactions, immunological reactions, growth, hormone-balances, etc., also limit in an equally specific manner the mental milieu to which the individual is able to adapt himself. It is generally agreed today that the adaptive capacities of a genotype in an environment are properties of the genotype as a whole and not a single sum of the capacities of its constituents. Personality analysis forces us to isolate in the person certain aspects for purposes of study. Individuality is thus split into many constituents which are not significant as separate parts but because of the manner in which they are integrated. Functions, traits, capacities and levels of consciousness cannot be treated as autonomous structures or forces but as aspects of complex organismal patterns.

It must appear paradoxical that with growing scientific insight into the components of individuality, current psychiatric orientations seem to ignore the principles of individual variation, of basic individual differences, and move rather determinedly in the direction of uniformity of criteria and values. We are told, for example, that all human beings have the same need for love and affection, and, moreover, an equal capacity to react to lack of love with feelings of rejection which in turn become instrumental in producing personality disorders of all varieties. We have endowed early frustrations, aggressiveness, hostility, a sense of insecurity, sexual conflicts and mechanisms of identification with a degree of psychodynamic omnipotence which tacitly implies a uniformity of personality structure and an equal ability of all people to become normally adapted members of the human family in—what some psychiatrists would regard as—the proper social environ-

ment. Ambitious claims regarding the effects of preventive psychiatry have their origin in this belief, which, as must be very seriously acknowledged, is an operational thesis of noble humanistic spirit, but which has, nevertheless, no substantiated claim to scientific truth. Modern science has demonstrated the uselessness of time-honored dichotomies, behavioral categories and separatistic studies of personality levels and has taught us the necessity for comprehensive understanding of the varied aspects of individuality.

The realization that any psychological state, by the sole fact that it belongs to a person, reflects the whole of a personality can help us greatly to clear up perpetual confusions which surround the idea of psychogenesis as opposed to other kinds of genesis. When we refer to psychogenesis we think chiefly of the causal relations between personal experiences and behavior. There is a prevailing tendency to equate social circumstances and life events with experiences, an error which has greatly contributed to the mismanagement of the concept of psychopathic personality. A social biography does not inform us about the manner in which events were transformed into individual experiences and it is, more often than not, quite presumptuous on the part of social workers, psychologists, and psychiatrists to decide whether certain events in a person's life constitute a trauma, an act of rejection or a motivational impulse. We have, it seems, been slow in acknowleding the fact that every individual experiences in his own unique manner and that the laws of relativity pertain to the meaning and definition of environment. Many needless arguments about causation of personality features could possibly be avoided if one would keep in mind that it is rather incorrect to conceive of environment as an entity with an objective meaning and that it would perhaps be more productive to use the term, environment, in the sense of individually-experienced environment. This would dispense with certain artificial divisions into factors which belong to the personality and others which belong to the social situation, since it would seem more essential to judge how the individual personality experienced that particular situation. Such considerations indicate the need for a differentiation of individual "experiential capacities" which we must envisage as distinctive individuality differentials.

Some very essential aspects of the attitudes of psychopathic personalities cannot be adequately evaluated unless one studies the manner in which their experiential functions seem to be characteristically altered. The question of their social behavior can then be understood better if we appraise, in every individual instance, how basic capacities have contributed to the formation of that person's social philosophy.

Psychopathic Disturbances of Personality Functions

We can gain some knowledge from a study of the psychopathological aspects of three main modes of dysfunctioning which do not exclude each other, but, on the contrary, co-exist, though under variable circumstances in the individual psychopathic personality. For this purpose, instead of isolating specific elements of psychopathic behavior (an endeavor unlikely to be successful in view of the lack of homogeneity of psychopathic personalities), we turn our attention to primary spheres of personality functioning, disturbances of which seem to create certain fundamental characteristics of these personalities. Clinical investigations indicate that the basic modes of dysfunctioning occur in the sphere of affectivity, conation and empathy. The individual psychopathic personality may show manifestations of light, moderate or severe disturbances in one, two or all three spheres, and may, according to the dominance of one or the other dysfunction, resemble a specific clinical profile. Individual analysis will show that all three dysfunctions play their part although one or the other will be of greater significance in a given case.

1. *Dysfunctions in Affectivity*

The prevailing mood imparts a specific coloring to the individual's manner of experiencing. To be reasonably consistent in one's attitude toward people, issues and with regard to self-evaluation, one must experience with some measure of affective consistency. The person who lacks this experiential continuity is bound to develop unpredictable, fluctuating attitudes in situations which, in the eyes of the average person, call for even and balanced judgment and behavior. Overdoses of mood variety have disruptive effects in as far as they interfere with adaptation to conventional social patterns. While we do not underestimate how cultural influences, training and the example of parents mold a

person's ability to control and direct emotional display, we also realize that the molding influences can only be utilized to the extent to which they come within the boundaries of individual adaptability. Certain dysfunctions of affectivity are fundamental components in the organization of personalities and find expression in distinctive life patterns. For reasons of simplicity, it appears practical to refer to these various patterns as modes of dysaffectivity.

What, briefly, are some of the inner repercussions of dysaffectivity? They are far-reaching and influence personality functions not only in one dimension, in the sense of lifting or depressing mood, but they alter and shape social, sexual, and intellectual attitudes. The experiential aspects of repetitious and unaccountable mood changes, for example, may have ominous cumulative effects. Self-confidence vanishes because rationalizations, which previously seemed to justify such mood episodes as understandable responses to situational factors, lose their plausibility. A person with some capacity for introspection may arrive at the conclusion, "I guess it's just me," an interpretation which constitutes good insight but is as consoling as the knowledge of having heart disease. Persons with little or no introspective abilities are prone to react with formation of projective ideas based on feelings of injustice in an allegedly or actually antagonistic world which loses patience and interest in them. Modes of dysaffectivity which are not of the crescendo-decrescendo variety but may occur very abruptly facilitate extreme impulsiveness and explosiveness. The affective change is frequently experienced with great intensity as indicated by such statements as "I suddenly saw red," or "A feeling hit me." The individual in a state of perpetually heightened irritability is annoyed by every triviality, and consequently conducts himself in a fashion which facilitates arguments and hostility. That is why what begins as an affective disturbance, ends by becoming a diffusely chaotic state of mind which interferes with all the social functions of the personality.

Affectively hyperkinetic individuals often seem incapable of experiencing a situation as an obstacle, as being improper or forbidding. They may consequently impress other people as being immature, superficial, shallow and irresponsible. Adventurous careers, risks taken without calculation of liabilities, failures which do not attenuate unwarranted optimism, epitomize the so-

cial careers of such personalities. In social life, their contacts are numerous but without duration. Intellectual and aesthetic interests change rapidly and conversions to new doctrines are not infrequent. The very idea of systematic approaches is foreign to such persons to whom improvisations and headline-thinking are more natural. Their uneconomical vivacity does not provide the soil for solidity in human relations, business or occupational activities and cultural orientation. An often pronounced tendency to lying and swindling seems to have its origin in craving for admiration and in need to cover up failures rather than in maliciousness or shrewd calculation.

Affectively hypokinetic persons often experience their lack of drive as incapacitating obstacles to social advancement. Reality judgment may be adapted to this mode of affectivity and find expression in doubt, bitterness and vague amorphous anxieties. Depending on intellectual faculties as well as on the severity of the disturbance, some persons may seem morose and sullen, others gloomy and dull, again others misanthropic, cynical or nihilistic. There are the "sad sack" figures, who may be unpopular to the point of social isolation.

Gloominess and uncertainty often become the foundations of an ever-growing mountain of anxieties and conflicts. It has become fashionable to devote more attention to the neurotic sources of social maladjustment than to those which are quite obviously actuated by affective dysfunctions. This is in no small measure due to the fact that many regard conflicts and problems as causative of the emotional reactions, when they should be considered as simply indicative of the affective state of functioning. Eugen Bleuler stated with classical simplicity and profoundness: "What we call psychogenic is mostly thymogenic." A factual appraisal of a person's affective functions could often save hours of obsessive effort to find a reason or conflict assumed to be the cause of every vague anxiety or mood crisis. We could derive satisfaction from the knowledge that in our steady search for psychodynamics, individual affectivity represents that source of personality functioning, the omnific-dynamic impact of which can neither be surpassed nor equaled by any other one.

The dysfunctions in affectivity are represented in various modes and degrees of severity in the individual psychopathic per-

sonality. What is most essential is their impact on vital inner attitudes through altered experiential functions.

2. *Dysfunctions in Conation*

Conation manifests itself as the motivational force which directs and impels strivings and efforts of the individual. It represents the purposive activities of the personality. What Schopenhauer called the "will" (the dynamic over-all force which is the basis of the continuity of life itself), is in many ways identical with what became known as instincts, impulses, libido or the id. Schopenhauer expressed in substance what has become a credo of modern psychology: that a man does not want a thing because it is good but finds it good because he wants it. The subject of conation is immensely involved because of the many personal, cultural and collective factors which enter into principles of motivation. Fundamentally, it is agreed that the forces of ethical imperatives, the example of good leadership and principles of training are of paramount importance and that, furthermore, there are basic motivational patterns, created by biological forces, which are beyond the sphere of will power or consciousness. The sources of these forces have been ascribed to multiple anatomical and functional units, to endocrine glands, cerebral engrams and temperamental dispositions. If we maintain the perspective of the total organism, we may define conation as an organismal manifestation of the sum-total of differentials which direct and influence purposive behavior. There are enormous individual variations of conative functions which find expression in fundamental behavior patterns.

For the purpose of this discussion, the meaning of conation will be confined to individual capacities for social striving, for perseverance and concentrated endeavor. To have, not only a goal, but also the ability for sustained effort, for taking pains and showing endurance, is indeed a very individual matter. Whether goal-formation is conditioned by special talents, by any kind of incentive or whether a person proceeds without a specific aim, the degree of successfulness in any endeavor depends in many ways upon the ability to cling tenaciously to the task at hand. The prototypical success-story of the one-time newsboy who has advanced to executive of an industrial empire, demonstrates among many other things the effectiveness of strong conative endowment. The verbalized motivation, whether presented in the form of altruistic ideals

or attributed to will power or destiny, is, nevertheless, related to inherent forces which drive certain personalities to sustain high levels of effort and to apply themselves perseveringly to their purposes. We may safely postulate, and it has been shown in psychometric evaluations, that intelligence, talent and imaginativeness remain mere potentialities without the forces of conative drive. This is often the case with many "once promising" persons who, in the judgment of the man in the street, "got nowhere because of lack of will power and weak character."

Psychopathic personalities show evidence of specific dysfunctions which manifest themselves as inabilities to sustain effort, to endure routine and to work methodically. If we examine how the experiential capacity of such personalities is adapted to their conative functions, we find almost universally feelings of unrest, of boredom and frustration in situations which call for concentrated endeavor. One often finds an emotional vacuum, a feeling of repetitious emptiness which promotes a craving for a change of scenery, for new faces and for sources of excitement. Such persons struggle forever with the phenomenon of evaporating enthusiasm. Initial enthusiasm runs high for new situations, jobs, or people; but it soon dissolves, and nothing is left to drive them toward their goal. In a way, such a personality can be compared with a car capable of a quick start and of speed but useless for touring.

The individual psychopath may rationalize his vocational failures in many ways. Not a few remain always convinced of their abilities and display arrogance and conceit. Confronted with criticism, they are likely to find fault with people, institutions or the structure of society. Others react with anxiety, often rather pronounced, to situations which demonstrate to them the discrepancy between planned performances and inadequate fulfillment. It is possible to distinguish between instability due to affective and due to conative dysfunction. While both are instrumental in the same person and are often so co-ordinated that they influence behavior in fashions which cannot be discussed separately, there are patterns of primarily vocational instability which are not associated with affective fluctuations. Clinical psychological investigations have contributed to the understanding of these dysfunctions. So-called motivity scores, which test volition, drive and perseverance, are characteristically lowered in psychopathic personalities while,

in the same persons, tests pertaining to intelligence, reality judgment and other areas of personality functioning may be normal or superior. Such defects can be discovered as early as infancy and are not infrequently associated with neurological manifestations of dyskinesia, enuresis and nail-biting. These children are restless, unable to concentrate in school and fail to adapt themselves scholastically or socially in spite of good potentialities in other directions. Emotional and behavior disturbances develop on a secondary basis, mainly because of the inability to adhere to any sort of routine program and discipline, at home or in school.

The social careers of psychopathic personalities, with predominance of conative dysfunctioning, depend, of course, not only on the severity of this disturbance but also on many other aspects of the personality. Those who are persuasive, intelligent and urbane can show a remarkable talent for extensive careers. Since they make an excellent impression on even sophisticated people, they may talk themselves into positions, confidences and marriages. Sooner or later, the false front of interestedness and efficiency collapses. Vocational instability becomes a matter of public record, forcing the psychopathic person to move and look for new hunting grounds. The less gifted ones are in and out of work and drift from one sort of occupation to another. "Quitting" often becomes the most frequently used item in their vocabulary. Their defensive explanations are honest on the basis of their valuations. In extreme cases, the psychopathic drifter has no goal at all and moves from state to state, from jail to jail. Such restlessness is fundamentally the pathophysiological lack of perseverance.

3. *Dysfunctions in Empathy*

The functions of empathy constitute the basic element in human relationship. Empathy, as the term is used here, signifies the capacity for "feeling into," in the sense of projecting one's own consciousness into another being. It must be understood from the outset that "feeling into" does not refer to detached or clever recognition of other persons' emotions but that it implies warm, emotional participation. Empathic experiencing represents a valuing function. As such, based on emotional intuition for the pains of others, it creates awareness of altruistic obligations. Empathic capacity thus becomes the prerequisite for love and friendship, for the promotion of individual efforts in the interests of the social

group. Educability depends in essential aspects on the student's empathic endowment, without which the teaching of social values, of duties or religious principles, can at best be superficially accepted but hardly be assimilated. The fundamental biological principle of the empathic function concerns social adaptiveness without which there would be no group survival. It is of great importance to realize that the formation of a person's conscience and his orientation to social judgments depends substantially on his capacity for empathic experiencing. With low empathic capacity, there is correspondingly low capacity for conflict. The person who cannot feel himself into the inner world of others, is quite naturally concerned with only his own needs and pleasures. When we appraise certain selfish or anti-social attitudes, we need to know how such attitudes are related to functioning or dysfunctioning in the sphere of empathy. A concept of "moral deficiency" which has so frequently found its way into scientific literature, is inexcusable, because it postulates moral forces as basic human characteristics and envisages *"ethos"* as some sort of trait. But all definitions of what constitutes moral behavior are contingent upon the codes of a given society and hardly apply to the biological laws of personality functioning. It appears more appropriate to examine specific functions which enable or prevent an individual from adapting himself to socialized behavior. And here, empathy emerges as a determining function.

Much of the symptomatology of cold egoism, emotional callousness, and aggressive violence toward the rights of others, so characteristic of some psychopathic personalities, arises in relation to lack of empathic endowment. This particular element of psychopathic behavior is perhaps the most universally-accepted criterion, probably because, in contrast to the other disturbances which are more harmful to the psychopathic individual than to the group, dysfunctions in empathy always involve or hurt another person, if not society collectively. One is tempted to declare that lack of empathic capacity puts the psychopath in the position of a stranger who does not speak the language. No matter how well he observes, imitates or pretends, he cannot understand the language of the tender mind. Lack of empathic feeling is not necessarily associated with frank modes of disturbing behavior. Generally, it manifests itself as a bold matter-of-fact attitude without emotional dependence on people. Satisfactions are derived in the most

crude fashion, and the principles of loyalty, substitution and sublimation have no part in the general scheme of things. More frequently, however, distinctive behavior disorders emerge early in childhood. In kindergarten, a psychopathic child already proves to be a very disruptive element and acquires the reputation of being a "bad" child. Tender care, domestic security and understanding parents have little influence; and even the most painstaking inquiry into the domestic scene and its psychological milieu fails to unearth evidence of plausible, provocative factors. In other cases, we find parental disharmony and poor supervision, yet other children, exposed to the same deficiencies, develop normally and do well in school and later in life. Factual observations of psychopathic juveniles reveal them to be cold in their responses to gestures of warmth and love.

Very essential are the relations of dysfunctions in empathy to criminal personalities. It now seems popular to subscribe to the generalization that all criminals are sick and, at least potentially, curable. This version again implies that all persons are equal in as far as they possess the same talents for goodness and badness, depending solely on parental behavior and additional early influences. But one cannot overlook that early unfavorable influences are not peculiar to delinquents and that, on the contrary, their emotional milieus may have been quite adequate. Many explanations of criminal personalities lack convincing substantiation with regard to the indisputable fact that the same social circumstances, inner conflicts, compulsions, fears, mechanisms of hostility, aggressiveness and identification exist in the minds of individuals whose totally different behavior is not expressed in criminal activities. The assumed cause which impels one person to commit murder exists for many other persons who do not become murderers.

The psychopathic criminal is, in many aspects, unsocial rather than antisocial. He has not, to begin with, the same potentialities for being good or bad because of his inherent, peculiar lack of empathic capacity. He does not necessarily hate society or cultivate a rebellious philosophy but rather lacks appreciation for meaning and value of the social structure. It is one thing to know the formal meaning of the law but quite another thing to utilize this knowledge for the erection of a hierachy of social values. Not all

criminals are driven by hate, conscious or unconscious, or compelled to be tough in order to prove their doubtful manliness. Criminal behavior may be facilitated by dysfunctions in empathy which, if very severe, may be found in psychopathic personalities who commit some of the most brutal and merciless acts of violence. Since severe dysfunctions in empathy preclude awareness of the effects of egocentricity on the feelings of other people, there is little occasion for the development of guilt feelings, desire for confession or atonement.

* * *

What, briefiy, are the general implications of these dysfunctions? It is always incorrect, and it leads to distorted prognostic and therapeutic attitudes, to refer to the fictitious entity "the psychopath." Recognition of specific dysfunctions dispenses with generalities on matters of psychopathic behavior which may, more often than not, mean an injustice to the individual patient. The disturbances involved differ decisively from case to case and offer dissimilar therapeutic prospects. Many are quite aware of their inner difficulties, they seek help, and they can be helped. There is no intelligent reason for the persistent superstition that the diagnosis of psychopathic personality has a connotation of character-malignancy, nor is it comprehensible why, if such should be the case, mere abolition of the concept could change the characteristics of those personalities who do not happen to have the capacities which are required for successful social careers.

Constructive psychiatric therapy aims at management of two phases: (1) the symptomatology of the moment, (2) the planning of a style of living which will permit the psychopathic individual to function at the best level commensurate with his adaptive potentialities. A psychiatrist who treats a psychopathic patient can sometimes be compared to an internist treating a patient with valvular cardiac dysfunctioning. In both instances treatment cannot effect the basic pathology but aims at restoration of a state of compensation. The cardiac patient who leaves the hospital compensated and who, moreover, has learned to adapt his physical activities to his capacity-potential, has been treated successfully. He may not have been cured but he has been enabled to function adequately. It is this principle of compensation versus decompensation which sets the background for the therapeutic management

of some psychopathic patients. Early recognition of these dysfunctions can lead us to adopt effective therapeutic measures which may be as important to society as to the patient, who can thus be protected from becoming involved in difficulties with which he cannot cope.

Delaware State Hospital
Farnhurst, Del.

PSYCHOSEXUAL ASPECTS OF HYMEN

BY ROBERT SEIDENBERG, M. D.

In cases of selective impotence and allied disorders, one is impressed by the inhibitory effects of the vagina apparently *per se*. Patients frequently relate that an erection can be had and maintained until entry is anticipated or attempted. At that time, the erection immediately disappears and sexual feelings end. Oral and sometimes anal entry may have no such inhibitory effect.

It is generally agreed that the cause of impotence is ultimately the threat or fear of castration. However, generalizations can not be made on the intervening mechanisms; these are of course dependent on the dynamics of the individual problem. Apparently the *castrator* can be mother or father or both.

When the symptom is associated with fear of the *vagina dentata*, Fenichel[1] has indicated that the male fears the vagina as the mother's mouth and teeth that would bite off the penis in retaliation for early cannibalistic or incorporative desires at the breast. In extension of this, Melanie Klein[2] states that the fear of punishment for destructive desires toward the mother's body is enhanced by anal frustrations in that the mother takes away the child's feces. Mother at this stage is the castrator.

In another essay Klein[3] declares: "The boy's oral-sadistic impulses toward his mother's breast are transferred to his father's penis and in addition rivalry and hatred in the early oedipus situation find expression in the boy's desire to bite off the father's penis. This arouses his fear that his own genital will be bitten off by his father in retaliation."

Klein further indicates that the dread of the mother is intensified by the fear of castration by the father, whose penis is thought to be present in the womb. From this, one may deduce that castration fears are initiated by a relationship with the mother, intensified by the father, yet may be produced by an apparent conspiracy of the two. Father is in mother; already incorporated within her. If he is within the womb and has malicious intent, entry here would be most dangerous.

Apropos to this, is the idea found in the myth of Hymen as described by Murray.[4]

"HYMEN OR HYMENAEUS

"Was worshipped as the god of marriage both by the Greeks and the Romans. His origin is variously stated to have been now from Apollo and Calliope, now from Dionysus and Aphrodite, while at other times he is said to have been by birth a mortal, and afterward deified. Properly speaking, he is a personification of the marriage song. There are various accounts of his life and deification and among them the following:

"Young, and of a soft delicate beauty, so that he might be mistaken for a girl, Hymen loved a young Athenian maiden, whom, however, because of his poverty, he could not hope to obtain for his wife. To be near her, he once joined a troop of maidens, among whom she was engaged in celebrating a festival to Demeter at Eleusis. Suddenly a band of robbers appeared from a hiding place, carried the maidens off to their ship, and set out with the intention of selling them as slaves in some distant country. But landing on the way on a dreary island, the robbers indulged so copiously in wine that they all fell into deep slumber. Hymen, seizing the opportunity, incited his fellow-captives to take the weapons from the robbers and slay them all, which they did. Thereupon he set off to Athens in the ship, and finding the people there in great distress, presented himself to the parents of the maiden he loved and undertook to bring her back unharmed on condition of their giving her to him as his wife. This was readily promised. Finding a crew he at once set sail for the island and speedily returned with all the maidens on board. For this he obtained the title of THALASSIUS, as well as the wife that had been promised him. So happy was his wedded life that at marriage ceremonies generally his name was on the lips of all the company and he himself in course of time came to be looked on as a god, and the founder and protector of marriage rights. At bridal festivities a sacrifice was offered to him, festal songs were sung and flowers and wreaths strewn."

In the foregoing myth, Hymen, by his soft, delicate beauty and powers of deception was able to hide among the maidens and at the propitious occasion induce them to disarm and slay (castrate) their captors. His role was that of planner and instigator, apparently being totally unsuspected by the robbers.

Hymen, through the ages, is the god and protector of the marriage rights. He is likewise the protector of the womb, walling off the entrance. It is significant that the name given to the membrane of the vagina should be derived from a male.

In interpretation, one can say that Hymen is father, standing guard, ready to instigate—and co-operate with mother for—the destruction of the approaching incumbent.

The idea of castration as a co-operative enterprise explains much of what one sees clinically. The meek, passive father may be as great a threat to the son as the classically cruel, overbearing, aggressive one. He may provoke more anxiety because his destructive powers may be disguised by a benign façade, as in the case of Hymen. The aggressive mother has already overpowered and incorporated father in Trojan horse fashion. Mother will likewise incorporate the son, and he will in turn be exposed to the destructive powers of both of them.

This mechanism was seen in two cases of impotence treated by the author. Castration fears based on pre-Oedipal complexes appeared to be inextricably connected to those produced by the Oedipus situation itself.

As a corollary to the thesis presented, if Hymen is father, then the ritual of defloration and its modern counterparts must also be re-explored.

Summary

The myth of Hymen may reveal the source of the dangers of the vagina as seen clinically. Hymen is characterized as a hidden instigator and may represent father who has been incorporated by mother. Both become, in effect, castrators.

410 State Tower Bldg.
Syracuse, N. Y.

References

1. Fenichel, Otto: The Psychoanalytic Theory of the Neurosis. P. 79. Norton. New York. 1945.
2. Klein, Melanie: Early Stages of the Oedipus Conflict, Contributions to Psychoanalysis. P. 206. Hogarth Press. London. 1948.
3. Klein, Melanie: The Oedipus Complex in the Light of Early Anxieties. P. 382: LII. Hogarth Press. London. 1948.
4. Murray, Alexander S.: Manual of Mythology. Pp. 195-197. Tudor Publishing Co. New York. 1950.

INTEGRATION OF EDUCATIONAL AND ADMINISTRATIVE PSYCHIATRY*

BY HERBERT C. MODLIN, M. D.

In psychiatry, as in no other medical specialty, hospital administrators are responsible for the success or failure of graduate education, and hence of future psychiatric practice. The latest American Medical Association listing shows a great majority of the approved psychiatric training appointments in non-medical-school and non-general hospitals. Of the total, 1,595 potential residencies, 33 per cent are in federal hospitals; 31 per cent in independent state, county, or city hospitals; 11 per cent in private hospitals; and only 25 per cent in medical school hospitals. Seventy-five per cent, then, of all available appointments are in hospitals outside the direct jurisdiction of medical schools. Less than half of the 1,600 positions are occupied, and vacancies exist chiefly in public hospitals.

That there is much seriously wrong with our large psychiatric hospitals, is widely agreed. Since many of them are dependent on public support and political action, and since institutional psychiatry as a whole has somehow failed to maintain the interest of the general medical profession; standards of minimal patient care have suffered in many hospitals, and standards of graduate psychiatric education have hardly existed. Improvements are gradually being made in many areas of institutional psychiatry; and hospital administrators who see their responsibility in the area of education will find opportunity to contribute splendidly to future psychiatric practice through the improved teaching of young physicians.

Attitudes of mental hospitals toward graduate psychiatric education can be roughly identified in one of the three following general descriptions. First, there is a passive view toward residents in training which might be expressed: (a) "Here are the patients;" (b) "Here is how the senior staff manages them"; (c) "Go thou

*Sponsored by the Veterans Administration and published with the approval of the chief medical director. The statements and conclusions published by the author are a result of his own study and do not necessarily reflect the opinion or policy of the Veterans Administration.

Presented at the 106th annual meeting of the American Psychiatric Association, Detroit, May 1950.

and do likewise." The resident who is working with patients on a trial and error basis is an apprentice rather than a student in an educational program.

A second attitude is reflected in a dichotomy of training and hospital practice. The educational program is grafted onto already established clinical services. Teachers are imported from a cooperating medical school or lifted from an attending staff to conduct case conferences or seminars; and the unfortunate result is that didactic training is sometimes only superficially related to the institution's practical day-by-day treatment and custodial functions. Since administrators are all too often preoccupied with regulations and procedures, or political currents or disproportionate personnel difficulties, and are hampered by traditional inertia or prejudices, a chasm lies between their dictates and the theory taught by attending physicians.

A third attitude is represented in integration of progressive, modern principles in hospital treatment with enlightened methods of graduate psychiatric instruction. This is the ideal. But, as the writer has mentioned, various hospital training systems fall only roughly into these three categories.

The tremendous expansion and improvement of hospitals and clinics by the post-war Veterans Administration has been one of the remarkable achievements of current medicine. It was complicated by the decision to improve standards of medical practice in developing extensive graduate teaching programs. Consequently, many V. A. psychiatric hospitals struggled for the first time to function as teaching institutions by integrating hospital administration, patient care, and training activities.

Winter Hospital in Topeka, Kan., is one of 37 V. A. hospitals approved for psychiatric residencies. It has the largest hospital training program in the V. A., and was among the first to initiate post-war teaching activities. Unlike some others, it started as a completely new project in January 1946, after taking over an empty 1,400-bed hospital from the army. The record of its growing pains in the subsequent four years illustrates many important problems in institutional psychiatry. Since it had no binding traditions, or the inertia induced through years of defeated hopes and struggles, changes have been rapid and abrupt and easily identifiable. In four years, Winter Hospital, which began functioning by

standard rules and procedures, underwent major and minor changes which, in another hospital and under the usual circumstances, might have taken decades of gradual evolution.

In 1946, Winter was a general hospital with beds for 200 medical, 200 surgical, and 1,000 neuropsychiatric patients. Each service was headed by a chief, and the neuropsychiatric service was divided for convenience into half a dozen sections: acute and chronic closed wards, acute and chronic open wards, a women's section, and an infirm section. With respect to teaching, Winter Hospital, during the first year of operation, perforce adopted an attitude similar to the second of the three just described. It had only a handful of staff physicians to develop the operational facilities of the hospital and to care for the new patients gradually filling its beds. Nearly all teaching activities were turned over to a group of interested outside physicians from the Menninger Foundation and several co-operating medical schools. Series of lecture courses and case conferences were devised. This plan was, from the outset, considered only a make-shift arrangement. The hospital management at all times sought to discharge the responsibility it felt toward constantly improving the psychiatric residency training program. As additional staff psychiatrists, clinical psychologists, nurses, and social workers were hired, each was considered from the standpoint of what he could contribute to the training program; and, when indicated, a definite portion of his time was set aside for teaching activities.

The administrators recognized as valid, recommendations from the education department that auxiliary teaching programs be considered essential in the hospital development in general, and the psychiatric residency program in particular. Consequently, formal training was provided for clinical psychologists, graduate and undergraduate nurses, social workers, occupational therapists, recreational therapists, corrective physical rehabilitation therapists, aides and chaplains. Approved residency appointments are now offered in the departments of medicine and neurology.

The dramatic progress within Winter Hospital's brief career, when reviewed in detail, appears little short of amazing. Almost every function of the hospital, including operation of dining halls, duties of stenographers, and writing of case histories has been revamped, revised, or improved under the philosophy of a combined teaching and treatment institution. The writer has arbitrarily se-

lected half a dozen examples of somewhat extensive administrative action which facilitated educational functions of the institution and refined the quality of graduate psychiatric teaching. These are offered to support the thesis that administrative psychiatry can contribute greatly to educational psychiatry.

First, and of basic importance, was reorganization of the duties of the psychiatric service chief. Strikingly illustrative of evolution at Winter Hospital are the job requirements of the chief of the neuropsychiatric service. In 1946, he was essentially an administrator responsible for patient care and all its related professional activities. He was accountable for adaptation of V. A. rules and regulations to the particular needs of Winter Hospital. His obligations concerned admissions, treatment, and discharge of patients; appeasement of relatives; supervision of personnel; and co-ordination of psychiatry with other hospital divisions. At that time, most resident education matters were handled through the director of education. Clinical assignments, much of the curriculum planning and some actual teaching required nearly the full time of a psychiatrist assigned to the office of education.

In 1946, an educator directed psychiatric residents, and an administrator supervised the psychiatric service. In 1949, these two activities were combined under the control of the chief and a new assistant chief of the neuropsychiatric service. Certain executive business was passed from them upward to the chief of professional services, while other responsibilities were delegated to the section chiefs. The psychiatric service chief, with his assistant, retained general authority over patient care, and organization and accomplishments of the neuropsychiatric service as a whole; and in addition, some previous duties of the education department and of the chairman of the dean's subcommittee for neuropsychiatry, were transferred to him. He interviewed applicants for resident training, worked as a member of the dean's subcommittee for neuropsychiatry, and conducted a lecture course and various seminars. As chairman of the curriculum committee, he became primarily instrumental in developing the formal curriculum. He assumed full responsibility for all clinical assignments, which he made after consideration of the residents' educational needs, as well as of the practical demands of the hospital. This integrated educational and administrative functioning of the service chief became a pat-

tern for the section chiefs, who, in turn, accepted teaching responsibilities commensurate with their clinical duties.

A second corrective administrative procedure was the division of psychiatry and neurology into separate services. At Winter, as at many other Veterans Administration hospitals, a psychiatrist headed the neuropsychiatric service. Under him a neurologist headed the 125-bed neurological section. The neurosurgeon was a member of the surgical service, in which the neurosurgical wards were included. With the co-operation of the chief surgeon, chief psychiatrist and V. A. central office, medical and surgical neurology were combined into a new service. First (a) the neurological section, as a unit of the neuropsychiatry service in a largely psychiatric hospital, lacked desirable influence and status. It was agreed (b) that in uniting their forces, the neurologist and neurosurgeon could more effectively represent their disciplines in teaching, and (c) this division of services made Winter more truly a general hospital.

Third in the program of administrative changes, was development of the psychiatric team. By the end of 1946, Winter Hospital had well-developed divisions of psychiatry, medicine, clinical psychology, social work, and nursing, each with its affiliated graduate training program. Although close co-operation in serving psychiatric patients motivated the personnel, physical separation in this large hospital, and unco-ordinated administrative responsibility and operation hindered integration of psychiatric practice. The clinical psychologists introduced a practical remedy for this condition. They recommended that their service be decentralized and their staff members and interns be placed physically and functionally under jurisdiction of the various psychiatrists who were section chiefs.

The social work department had already achieved some flexibility of this type, and the laudable example of the psychologists stimulated the other disciplines toward further decentralization. This modification was intended to aid students in the various training programs in experiential working together, and in learning by means other than didactic lectures, the contributions of each professional person to total psychiatric practice. As the needs of the patients indicated, psychiatric teams were organized in each section of the hospital and even on individual wards. On the closed psychiatric wards, psychiatrist, nurse, aides and social

worker formed ward teams, with a clinical psychologist as consultant to two or three such ward groups. On some open wards, psychiatrist, psychologist, and social worker composed the nucleus of the team, the nurse not included since she is little needed there. On the psychosomatic section, psychiatrist, internist, nurse, and social worker were the basis of the team. On the infirmary section, psychiatrist, nurse, aide and occupational therapist formed a permanent organization. In each instance, the ward or section psychiatrist was team leader, with responsibility for the patients' care and for the team's performance, which was centered around complete psychiatric practice rather than the separate disciplines of the participants.

A fourth administrative innovation involved the establishment of a psychosomatic section. In most V. A. hospitals, medical, surgical, and psychiatric services exchange consultation and jointly participate in general staff conferences, but are separate in administration and practice. The original Winter staff desired to teach residents the holistic psychosomatic concept of illness; and they recognized at Winter Hospital a discrepancy between existing medico-psychological practice and what they considered a necessary standard. Accordingly, through altered administrative policy and a far-reaching shift in hospital organization, they incorporated a large number of the open psychiatric wards into the medical service. Currently, an internist is chief of this service, with another internist and a psychiatrist as assistant chiefs. Three senior internists and two senior psychiatrists, together with 10 psychiatric and 10 medical residents complete the staff. Each ward of 20 patients is staffed by a psychiatric and a medical resident, and co-supervised by a staff psychiatrist and internist. A patient newly received on the ward is managed by both psychiatrist and internist to the extent that his illness indicates. All medical and nonpsychotic psychiatric patients are admitted to this service where, on its admission ward, they are evaluated for seven to 14 days by the intake team, consisting of internist, psychiatrist, psychologist, social worker, nurse and aides. From there patients are either discharged or transferred to the appropriate psychosomatic ward or other hospital section. All professional personnel on this section participate in the combined teaching program, which includes weekly case conferences, psychosomatic seminars, and a psychosomatic journal club.

A fifth administrative move contributive to advancement of an integrated program was rearrangement of open and closed wards. In the early days of Winter Hospital, it seemed expedient to adapt personnel and patients to the arbitrary architecture of this military installation. Thus the standard of grouping patients according to social behavior was adopted. Respective sections of the hospital were designated for acutely-disturbed or newly-psychotic, for chronic, and for convalescent patients. As his condition changed, a patient was shifted to the appropriate ward or section. If acutely disturbed when admitted, he could be expected to progress from admission ward to disturbed ward, to shock ward, to closed convalescent section, to open convalescent section, and then perhaps to discharge.

Therapeutic benefits from such progressive shifting are seriously jeopardized or even undone by the concomitant frequent changing of doctors and other personnel. Many relapses are the consequence. These circumstances are a handicap to teaching residents a longitudinal view of mental illness. The efforts to correct deficiencies in patient assignment gradually led to the present arrangement of an acute admission section and two relatively equal, continuous-treatment sections, each with open and closed wards. After transfer from the acute section to one of the convalescent sections, a patient may be shifted from ward to ward within the section, but he retains contact with the same doctor, social worker and nursing supervisors until discharged. Resident physicians and other professional students on a section can now follow longitudinal development or remission and observe an individual patient's response to treatment and management during a prolonged period. This learning experience is invaluable. The following administrative maneuvering was required: (a) Appropriations, to remodel wards from open to closed, and vice versa, had to be fought for; (b) some duplication of effort on the two sections necessitated a slight increase in personnel; and (c) a greater variety of patients on each ward and section exacted more flexibility from the personnel. All these difficulties were surmounted with resultant profit to the training and treatment programs.

A sixth progressive administrative influence resulted in the setting up of a group dynamics section. The practice of group therapy at Winter began in 1946, as an experiment but continued as a

valuable learning experience for residents and a valuable therapeutic experience for patients. It became apparent that an effectual setup would necessarily be extensive and permanent. A sustained interest in the development of group therapy led to the exploration of general problems of group dynamics; and most of this work was concentrated on one section of the psychiatric service.

Other therapeutic methods as indicated, are used there, including individual psychotherapy under supervision. Individual therapy is assuredly requisite in meeting many patients' needs, and at the same time provides an excellent contrast to group therapy experience for the residents. Two residents are assigned to each of the five wards, and they conduct the therapy groups on each ward. A patients' club on each ward elects officers, devises projects, makes representations to the administration and in other ways acts as a social group. Considerable administrative enlightenment and alteration were necessary in implementing this program. A section staff physician was sent to study group therapy methods elsewhere and, on his return, was assigned nearly full time, as teacher and supervisor, to the group projects. Unusually tolerant attitudes were required toward this section; since the patient groups were prone to "act out" by approaching the management frequently with committees of protest, complaints and demands regarding the quality of services and facilities, and with schemes to improve them.

To recapitulate, these are six examples of administrative action at Winter Hospital which positively affected the development and strengthening of the residency program:

1. Reorganization of duties of the psychiatric service chief.
2. Division of psychiatry and neurology into separate services.
3. Development of the psychiatric team.
4. Establishment of a psychosomatic section.
5. Rearrangement of open and closed wards.
6. Development of a section for group dynamics.

One would, of course, prefer to report success only, but it must be stated that there were many false starts and predictions. Some of the innovations which looked good on paper proved wrong when put into practice. Much reviewing and reversing, modification and

rectification were necessitated. There is no complacency in the position attained; nor does anybody anticipate a hurdle-free course ahead to a greater integration in functioning.

The innovations described were eventuated by seemingly paradoxical principles of personnel practice—decentralization and co-ordination. The hospital administration, from the manager to division and service chiefs, relinquished controls and delegated authority downward. Coincidentally, increased co-ordination was implemented in the lower section and ward units. This could be illustrated on the familiar organization chart as a weakening of control and authority in upper vertical lines and a strengthening in the lower horizontal.

Implicit in this plan's successful working, are administrators having a progressive and enlightened philosophy of psychiatric practice, understanding their mighty responsibility in the field of graduate education, and believing that the best hospital for patients and personnel is a teaching hospital. Such administrators condition a climate conducive to the growth of psychiatry in the rich loam of advanced educational methods.

Menninger Foundation
Topeka, Kan.

HYPNOTHERAPY IN A CASE OF AMNESIA WITH SUICIDE ATTEMPT

BY ADOLF ZECKEL, M. D.

Some time ago a 24-year-old girl was referred to the writer by another psychiatrist who felt that hypnotherapy might be indicated. The patient had been found unconscious in her gas-filled apartment, the jets in the kitchen wide open. Her girlfriend, who had found her lying on the bed, got her, with help, to the roof where she was immediately seen by a doctor and revived in a short time.

As far as could be found out later, when checking up on the incident, this had been an almost successful suicide attempt. A chemical analysis of the blood was deemed unnecessary because of the situation in which the girl had been found. When she came back to consciousness, she said she could not remember having intended to commit suicide. She did not recall having opened the gas jets. In fact she did not remember anything covering a period of several hours on the day in question. She said, however, that several times in her life she had experienced episodes which one might call fugues and amnesias.

The manner in which she recounted her life history indicated that she felt she was not really sick, although she admitted she was somewhat worried about what had happened. She denied having any problems of importance and declared with certainty that she had no reason at all to take her life.

It was during the beginning of the first treatment session that it became clear that the suicide attempt had not been real to her, but rather was some kind of a strange coincidence.

The history and findings during her treatment, as well as the result and the specific indications for hypnotherapy, seem to the writer to be important enough, and of sufficient interest, to warrant publication of the case. On the day of the first interview, March 2, 1949, and on the day of the last visit, March 29, 1949, Rorschach tests were performed by Dr. Rose Palm, psychologist. Test results will be briefly mentioned later in this paper.

The history given during the first interview is the following:

The patient's parents were involved in divorce proceedings which she said did not disturb her in the least. She was rather worried about her mother's health. Her mother was suffering from glau-

coma. She felt attached to her mother. She was afraid that her mother might get worse if she heard of her suicide attempt. If it were possible, she also preferred that her father not be informed. The father was an alcoholic who, in her opinion, had not treated her mother well. However, she was not on bad terms with him. He was going to re-marry and the patient thought it was the right thing for him to do. She knew his prospective wife and liked her.

She had a married sister who was two years older and a single brother two years younger than she. She always got along "just fine" with both of them. At the age of 17, she had had a boy-friend who had been with the navy and had perished in a submarine. She had been extremely upset about his death. A few years later she had become engaged to another boy. They had not gotten along so well, and both decided, in a friendly way, to break the engagement.

Now she was engaged to the best friend of her previous fiance. She said that she liked this boy a great deal and that they intended to marry soon. She had not yet had sexual intercourse, but she said she had experienced orgasm from love-making. She did not have conscious guilt-feelings about her sexual activity, and she said that she looked forward to married life. She hoped to have children. The patient and her fiance planned to wait for sexual relations until they were married. She said she had never masturbated nor felt the urge to masturbate.

The patient had always been impressed by the kind of nomadic life that her family lived in her youth. She recalled that the family had moved at least 15 times from various little towns in the midwest.

As to her amnesic phases, she could remember having had such episodes five times before the suicide attempt. The first time was when she was 14 years old. All she knew was that an evening passed about which she could remember nothing. The next morning she had had a feeling of uneasiness about not being able to recall. This happened at the time of her first menstrual period. She connected this episode, somehow, with her father's having been drunk and having driven with the car into their garage, hitting it and hurting himself.

One year later, she had gone out one morning to climb about the rocks at a quarry. She had slipped and was pinned under two heavy rocks. She could recall nothing of the rest of the day until

late afternoon, when she had "regained consciousness." She had worked her way out, scratched and bruised. She recalled having gone home bleeding and crying.

She had the third spell of amnesia in Washington two years later, when she was 17. She had had a job there and one morning had "fainted" at about 10 a. m.; she "came back to consciousness" at 11:30 a. m. The doctor believed that she had fainted. She could not remember what she had done during the whole morning preceding the fainting spell. At that time her boyfriend had been in and out of Washington on shore leaves, from a submarine escort. She was often afraid that he would die and was always worrying about it.

Five years later, the fourth episode occurred. She had regained consciousness at the bottom of a flight of stairs at about noon after having gone through an ordinary working morning, nothing about which she could remember. Coinciding with this episode, was the visit of her present fiance. He had talked to her about a pressure sensation in his head for which he had wanted to consult a doctor. The patient felt greatly upset about this.

The fifth spell occurred two weeks before the suicide attempt. She had gone to her job one morning, telephoned for an appointment with her union leader and started off for that appointment. The next thing she was able to remember was wandering around in New Jersey in the late afternoon.

On neurological examination, there were no findings of abnormality whatsoever. A complete physical check-up by a specialist in internal medicine revealed no internal disturbance of any kind.

The writer felt that procursive epilepsy had to be excluded if possible before a definite diagnosis could be made. An electroencephalogram was made, and the report was: normal electroencephalogram, no indication of epilepsy and cerebral pathology (Dr. Hans Strauss).

Some of the highlights of the Rorschach report follow (first report):

"She is greatly handicapped by a severe depression and by feelings of hopelessness and despair, great amount of guilt, frustration and repressed hostility. Conflicted in regard to both parents. Maternal figures are seen as witches. The Rorschach test reflects a traumatic disturbance in regard to the father. He is seen as lying down, his big genitals protruding, showing 'bushes of hair.'

There is such persistent referral to the sight of pubic hair that one may assume this has been a very upsetting experience. Strong sado-masochistic conflict in regard to the father's genitals. Strong death-wishes, repressed, against the father, probably originating from the wish to destroy his genitals.

"The paternal genitals take on the form of foods which should be destroyed by eating, frying or roasting them.

"Fear of being attacked by the father is also shown in the test.

"Penis envy, exhibitionistic and voyeuristic tendencies.

"Feelings of being strangled and claustrophobic anxiety are indicated. Conflicts regarding her own sexual functioning and regarding pregnancy and abortion, feelings of severe guilt and depression."

All in all, this Rorschach shows such extreme frustration and depression that suicidal tendencies would seem possible. The patient is in great need and reaching out for help. She is able to relate to people and may be considered a good treatment risk. There is an over-strong fantasy life with occasionally a touch of confabulatory thinking. There is no evidence of psychosis; it is a compulsion neurosis picture.

This Rorschach test was done without any knowledge by Dr. Palm of the history of the patient. For the sake of getting an objective test-result, the patient was requested not to discuss her history, and Dr. Palm was notified of this fact. As will be shown further in this paper, the test proved to be extremely helpful, and its indications were confirmed, by and large, by the facts which were disclosed in the hypnoanalytic sessions.

Before the writer terminated the patient's first visit, he decided to test her hypnotizability. She was readily put into a deep hypnotic trance; and, this time, amnesia for what would be discussed was suggested. She was brought back to the last amnesic episode, which occurred the day she was found unconscious. She said that she had waked up in the morning with a choking sensation. During the telling of her story, her pseudo-gay, almost light-hearted, slightly flirtatious, attitude was gone. She was completely serious. She said with great emotion that her sensation of choking reminded her of her second boyfriend who had been taken to the hospital with a severe attack of asthma and who had been quite blue in the face. "It is all because I do not want to marry him. I am guilty of his illness. I am no good. I should not marry.

Jack (her present fiance) has a pressure in his head. Maybe he has something seriously wrong with his brain. It is all my fault. I should die." She then proceeded to tell the writer that she would die by gas and related how she proceeded to end her life. The writer told the girl that she would feel greatly relieved upon awakening and that, although she felt so guilty, she had never done any real harm to her boyfriends and would no longer feel a desire to punish herself for her fantasies or even her wishes. She woke up, smiled her friendly and innocent smile and wondered whether she had told anything of importance.

The patient pleaded with the writer to delay notifying her parents for a few days until he had decided what ought to be done. The writer made contact with her fiance, and it was agreed to see what hypnotic treatment would do.

Although intramural treatment in a case like this would have been by far the safest thing, the writer felt that the first contact in hypnosis was sufficiently promising to try ambulatory treatment. Besides, he was more or less compelled to do so. The choice was to send her to a city hospital with the probability of her being committed to a state hospital, which would undoubtedly result in an enormous shock, or—with the support of her fiance, and in a day or two, her parents—to undertake a treatment which might give her help without her undergoing the shock and the consequences of being hospitalized. The main factor that made the writer decide on the latter course was her excellent hypnotizability.

The girl's probable diagnosis was hysteria; the differential diagnosis, between this and epilepsy, psychopathy and schizophrenia. At the first interview, no signs of a compulsion neurosis were found.

The next day, the patient readily fell into a deep trance again. She talked about her guilt-feelings toward Jack. She wondered whether it were all her fault. "Maybe he is very sick. It could not be, could it?" She asked this in the tone of a child who has done something bad and wants the grown-up to console her by telling her that it is not so bad as she fears.

Again the writer told her that, even if she felt it was her fault, reality is different, that she could not have caused his sickness, and that she would feel relieved. She woke up again with complete amnesia. Before she left, she said that her mother would

come the next day and that she might wish to see the writer. Her mother's visit was welcome, but the writer was surprised, since the patient had first requested that the therapist keep the story away from the mother because of the mother's glaucoma. The patient, however, said that she felt unable to hold the information back from her mother.

The mother proved to be rather upset about the matter, and her information about the girl's past confirmed what the patient herself, so far, had related. The mother knew nothing about the amnesias, but she remembered the quarry episode very well and also had wondered at that time why the girl had stayed there so long. She and her husband had gone to the place in the quarry and had found evidence of a struggle. The writer asked the mother to inquire about the exact circumstances surrounding the incident of the patient's having been found unconscious through gas. She told what she had learned at the patient's apartment—that her daughter had been immediately evicted by the landlady when it looked as if the suicide attempt had been a real one.

During the third session, the patient related, in hypnosis, a dream which was rather vague. She had dreamed of a boat. This reminded her of her brother, who was in the navy, just as her first boyfriend was. She talked about the dangers of pre-flights. She often thought that her brother's plane might crash and that he might die. Reassurance was given again.

In the fourth session, hypnosis was tried, but she could not be hypnotized. After a while the writer told her that it did not matter and that it was just as well if that day she told what came to her mind. She began to talk about her relationship with her father. She was not close to him. It was always "as though he were not there." However she followed this up by relating that once he had not come home when he had had a quarrel with her mother. The girl was afraid that he had committed suicide. Finally he came home at 7:30 a. m. and was drunk. He immediately engaged in a row with his wife. The patient continued by telling that once when she was about 19, she and her father were out of town in the same hotel. He was drunk, tried to seduce her and get her into his bed. She laughed it off, thinking this the best way to ward him off, and went to her own room.

Immediately, the writer interpreted to her that she could not "sleep with me either" and that apparently the hypnotic treatment

was to her similar to the seduction by her father and that this was the reason she could not afford to go to sleep on the couch.

The patient then continued in a waking state to talk about her hostility to her father. She recalled actually having wished his death. She also remembered having had death wishes in regard to her brother and to the three boyfriends whom she had had so far. She said, "Maybe I wanted to destroy them." She was asked about her upbringing in relation to sex. She said that at home they knew almost everything, that living in the country had acquainted her at an early age with the way animals mate. As to humans, she remembered that she always saw all the members of her family naked. She could not recall that this made a special impression on her and apparently did not consciously attach any importance to the observation of the difference in sex anatomy.

At the fifth session, it took a longer time than in the first three sessions to hypnotize her. She was told that the next day she would walk into the room, lie down on the couch and immediately go into a deep sleep. This time she first talked about the amnesic spell preceding the suicidal episode. She had had an appointment with the union leader, but, "I cannot stand it longer in New York, I have to go, Jack is in New York, I cause him to worry, I make him sick, I go away, I go to New Jersey first, away, he should never see me again."

The writer decided to use the technique of age regression described by Spiegel, Shor and Fishman[1] in order to get information about her previous amnesic episodes. He disoriented her as to time and suggested that she was getting younger, that she had reached the age of 15. The writer then told her what she had related about the incident in the quarry and suggested that she tell all that was going on.

In relating the story she used the present tense, off and on, as though she were really re-living the episode, with all the freshness of an emotional experience. At another moment she suddenly spoke again in the past tense and seemed to be aware of the writer's presence. "I did not want to go to sleep so early. Mother is mad at me. She says that at my age I should go to bed in time. Father is drunk. They had an argument. Finally father threw a glass at mother. They are fighting about me but I hate him [with anger like a child in a rage, whispering a few times] I hate him, I hate him. The next day I went to the quarry. I think of

how father hurts mother. I get my foot and leg between rocks. I am furious. I hate father. I wish he were dead, an automobile accident. I want to do the same thing to him as he does to mother. I want to hurt him, he should die. I wish he had been killed yesterday in the car. I feel my leg hurt between these stones, it hurts, he should have pain, he hurts mother. I feel pain, serves me right. I am bad, I should bleed and have pain." The patient was speaking as if she were in great pain; she whispered occasionally and was panting. Obviously she was feeling great emotion.

When the emotion wore off, the writer suggested amnesia to her and told her again in simple words that her anger was understandable, but that it belonged to the past and that she was grown up and would not feel guilty about past wishes of great violence. She then woke up, showing, as usual, her innocent smile.

She entered the room for the sixth session, changed the couch cushion as she had been told to do the day before, lay down and was immediately in a hypnotic trance. The trance was deepened by the usual suggestions of not being able to lift the limbs, etc. She was brought back to the time of her first menstruation when she was 14 years old. She had not felt well and had not wanted to go to school. She first had had a fight about it with her mother and later on with her father. She had cried, but was forced to go to school. She emotionally re-lived her situation in the hypnosis. She had cried all evening and had felt misunderstood. There was amnesia after the hypnosis.

In a waking state, she reported that she had had a "funny dream" in which she was chased by a bear. She did not remember any details.

At the seventh session, the girl was told that she was going back to a much earlier time of her childhood. She was regressed to the age of six to eight. She then began talking, by saying that she was in school and had to recite a poem. Never before had she had any trouble in front of the class. This time she could not find the words. She felt ashamed. "The evening before I was playing bear with Daddy. We all have fun. I go to bed. I have a dream of a bear chasing me. I wake up. I am frightened [whispering] I better go and tell mother. I see Daddy. Oh, mother is not home, she is sick and in the hospital. What is Daddy doing there? He is lying on top of a woman. It is a strange woman. He is not nice that he does that, he hurts mother. I go quickly out of the room.

I cannot fall asleep again. I am afraid of the nightmare of the bear. The next morning I could not talk to Daddy. At school I could not recite. In the evening Daddy wanted again to play bear with us. I do not find it fun to play bear now." Complete amnesia followed.

After hypnosis, therapist and patient talked about school when she was seven. She said that there was a lot of reciting. She was asked whether she had ever had any trouble in reciting. She said: "My sister and I like it and had never any trouble in reciting. Oh no, for that we were too much show-offs, all three of us!"

It was quite clear that the memory of not having been able to recite a poem at school was something to be repressed, since it seemed to be too closely tied up with the painful witnessing of her father's extramarital intercourse—and the exclusion of herself from the primal scene. It is interesting that in the waking state immediately following, she completely denied her school difficulty, claiming that all three children of her family were show-offs!!

She was questioned then about her mother's health at that time, and she said that mother had undergone treatment for fibroid tumors and was in the hospital. Daddy took care of the children and her sister cooked.

After what came out in this session, it became clear as to what the "funny" dream of being chased by a bear, related in the previous hour, had really meant. The treatment not being an analysis and being much less ambitious in its scope, the writer felt it was not opportune to interpret to her that her deeper wish was to be chased by her father and that it was she who had desired that he make love to her. At this time one could only reach for the goal of making conscious the hostile sentiments directed to her father, and relate them to her symptoms. A deeper understanding was to be omitted and left to an analysis, if that were decided upon in the future. The bear game memory related in hypnosis showed clearly that the bear chasing her in the nightmare, immediately after the real play, was the father. It was a bad father rejecting her mother, meaning really rejecting and excluding herself, as was demonstrated after her observation when awakening and entering the parental bedroom. Besides, she remembered in the waking state, after the session in the writer's office, having witnessed her parents' intercourse. In "The Bear in the Haunted Mill" Róheim[2] discusses the symbolic meaning of the bear in folktales. In these

stories, the bear is the giant father. The Rorschach findings in this case indicated the existence of disturbing experiences in connection with the sight of pubic hair. The sight of the father's genitals in the primal scene, or apart from it, would be another reason to have had the father in the dream and nightmare represented by a furry animal like a bear. In Róheim's paper it is the son who has to destroy the bear or the giant (the father) to acquire any woman, always representing the mother. In the writer's patient, the bear seems to be the father as he was seen in the primal scene. He is dangerous to her because he might awaken her dormant passive-feminine wishes in regard to him.

There was hypnosis as usual in the eighth session. Age regression to a time of about five or six was tried. The girl spoke in the past tense about paper and crayons which she had got and which had been "so nice." The writer then told her that she would see exactly what was going on. She was told that she was six years old. A long silence followed. Again the writer said: "You are six and it is your birthday. Tell me what happened." Again a silence. Then she blurted out in an indignant way: "I am not six. I am 24, and it is not my birthday either!" The writer then discontinued hypnosis and discussed her resistance.

She declared that she had not felt well after the previous session. She had suddenly remembered a lot of things. She had been thinking of her parents and had recalled that she had witnessed their intercourse. She had thought as a child that she was the child of her father, not of her mother, and her older sister had confirmed her in this belief.

As the primal scene memory came up after she had related the incident of her father with a strange woman, the writer felt that he could talk with her about some of the information she had given in the session the day before. She remembered it with some surprise and was amazed she could tell about all of this.

At the ninth session, she was completely refractory to hypnosis. The attempt was given up, and then she reported that her father would come to New York. As she had done with her mother, the patient had also written to her father and, as the writer found out later, she had stressed the fact that she had tried to commit suicide!

This time she said that she felt nervous: "Maybe Dad wants to see the doctor." She had no objections!

The scheduled tenth session did not take place, since the patient did not come for her appointment. About two hours after the time set for it, the writer was called by the father, who was with his future wife at the patient's apartment and had found her asleep. They could not wake her up and were greatly alarmed, requesting immediate medical attention. When the writer arrived, the patient was just waking up. She said she had taken some sleeping medicine. She also was menstruating, and gave the impression of not being alarmed herself, since she considered her late waking as the result of having been very tired and having taken a drug. It was then about 6 p. m.!

The next day, the patient was seen for the eleventh time. Hypnosis was not possible and her relationship to her father, of which she had become better aware, was discussed. She realized that whenever her hostility came too close to awareness she lapsed into an amnesic spell or, as the day before, into sleep. In this period of oblivion, she re-lived her hostile, very violently aggressive and sadistic feelings, or, as in her suicide attempt and on a few other occasions, turned the sadistic content against herself. This had been especially clear when she bruised herself in the quarry, and, as became evident in the hypnotic session, it was obvious that hurting herself was really identical with hurting her father. The punishment intended to be meted out to her father was present in this so-called sleep. The writer did not know whether the last episode, in which she overslept her appointment with him, was entirely malingering or whether it could also be considered a hypnoid equivalent. He was most inclined to think of simulation, but does not think that this makes a very great difference. That she consciously wanted to punish her father came clearly enough out when she wrote him about her suicide attempt.

At the twelfth session, hypnosis was possible, but rather superficial. Without much emotion, an early childhood incident was related. She was playing in the park, aged four. A little boy with whom she was playing exposed his penis.

After the hypnosis, the past revelations were discussed again, and the patient got insight into the isolation from her real life of her hostile, violent feelings toward her father by her symptoms of denial, isolation, reversal and turning against the self. It also became quite clear to her that she had equated her brother and her three boyfriends with her father and that the death-wishes

related to them were—on a deeper level—her hostile wishes toward her father. Deeper aspects of her masochistic experience in the amnesia and her more passive-feminine desires toward the father could not be looked into, since this inquiry would not have been understood. Besides, the benefit derived from the treatment was such that it seemed that the patient had better insight and had begun to feel that it was possible to harbor hostile feelings consciously without feeling too guilty. The connection of this insight with the symptoms she had produced was clearly felt. The last four sessions did not reveal much. The therapist could not again get her into a deep trance. He felt that she was consciously and unconsciously reluctant to have more treatment.

The reason for this reluctance was evidenced when, the day before her last session, her fiance wanted to talk to the writer. The patient had told him something which she did not want him to tell the therapist. It was explained to him that she probably did wish him to tell it and that he was to act as an intermediary. He then said that the girl had been taking sleeping pills for years and had confessed to him with shame.

When the writer saw the patient, she confirmed this information. He did not act surprised and told her that when she felt relieved by the treatment she would be able to give this habit up. She confessed that she had been afraid that the therapist might, going on with the hypnosis, forbid her to take the pills and that this was one reason that she broke treatment off.

The patient said that she felt greatly improved and relieved. She planned to marry soon and meanwhile to look for a job. A few weeks later, the writer saw her fiance again. He again had a big secret. The girl had told him that she was guilty of the death of an automobile driver. In her childhood (she could have been about six) she had been playing on the street with a little boy. They were on opposite sides of the road, throwing a branch of a tree at each other, catching it, and throwing it again. Suddenly a car passed with great speed and the branch obscured the windshield for a moment. They saw, for a split second, the driver turning his head around with an angry look at them and then crashing into a tree. Both children ran away scared. The boy made her promise never to tell anybody about it. They learned a little while later that the driver had been killed. It is obvious that this guilt was tied up with the death-wishes toward her father. The

fiance, who had been kept up to date by the patient, felt that this was the real clue to all her troubles. Although one may doubt the patient's veracity, it makes no basic difference whether this incident really happened or was confabulated.

The Rorschach examination already had indicated her tendency toward confabulative thinking. However, whether reality, distortion or confabulation, this story was a part of her hostile feelings in relation to her father. The writer learned that she and her fiance had planned a definite time to marry but that the patient had, some days before the end of the treatment, broken the engagement. She did not want to see the boy any more, not giving any reason. They did not see each other for a few days, when suddenly he saw her, as if by chance, walking in front of his house. She had "had some shopping to do." She had not wanted to meet him. Result: The engagement was on again.

Not much later, the writer received a letter in which the patient wrote that she was feeling "excellent," that she was employed outside New York State as a teacher, that she planned to marry very soon and had set the date. She invited the writer to the wedding. A wedding would never have taken place without the treatment, she wrote.

Diagnostic Considerations

In reviewing the case, the writer came to the conclusion that the diagnosis could not simply be restricted to hysteria with fugues and amnesic attacks. Her confabulation and her addiction to barbiturates made the writer feel that she also had mild psychopathic traits. No clear-cut symptoms of an obsessive-compulsive syndrome were found. Schizophrenic mechanisms, too, were absent; her contact with people was not of a schizophrenic nature, and her symptoms were of a non-psychotic type. After the unfolding of her hostile attitude to men, which had been kept unconscious, she could give up this non-realistic hostility to a great extent. Of course, the hypnotherapy was not a psychoanalytic treatment. The patients' homosexual attachment to the mother was not even touched, her mendacity was not analyzed, her masochistic desires toward her father were not worked out. Nor were her incestuous feelings in relation to the brother, who was equated to her father or boyfriends in her death-wishes, ever brought into the open. At the beginning of the treatment, immediate help was necessary since

the girl had made an attempt at suicide. Therefore, psychoanalytic treatment was not even considered. If she were not to be hospitalized, quick psychotherapy had to be done. At the end of her treatment, the therapist discussed with her the great desirability of going into analysis, in the town where she was to live, as soon as she could possibly afford it. She realized, by this time, the need to enter psychoanalytic treatment.

At the time of discharge, another Rorschach test was performed by Dr. Palm. Again high intelligence was displayed; an original and creative mind was found; it was suggested that the girl might do well in writing children's stories. This time there was a definite increase in ability to express herself and to channelize fantasies into a creative outlet. The oral aggression in regard to her father's genitals seemed to have lessened markedly. There was also no reference at all to the frightening sight of the pubic hair, a feeling which was strongly expressed in the first examination. Feelings of hopelessness and despair had undoubtedly lessened. Though the evidences were markedly decreased, the present Rorschach still showed depressiveness, feelings of guilt and of frustration. On the whole, there was, however, a much better contact with reality, and the girl was better able to absorb and control her depressive feelings. While the depression was much less severe and the ability to control it much better, there was still some danger of suicidal drives, mainly resulting from frustration and guilt concerning homosexuality.

The Rorschach results not only confirmed, but very strongly accentuated, the writer's opinion that the patient needed further treatment. It was felt that since she had improved remarkably and had become increasingly difficult to hypnotize, the only right treatment which would be satisfactory in the long run would be analysis. Right now, this seems to be a plan for the future.

A few remarks should be made about the dynamics involved in different stages during the hypnotic treatment.

Of interest in this connection, was the fact that the patient coming for her fourth treatment was refractory to hypnosis. This resistance was interpreted to her after she had related the memory of her father's having tried to seduce her. As in the whole treatment, the writer refrained from interpretation on a deeper level and proceeded to correlate the hostility—which had become more conscious—with her present condition. After she had re-

lived her almost nightmarish experience with her father during the seventh session, she returned and was refractory to deep hypnosis. The writer understands this resistance as a sign that he and the patient had in no way solved the transference, which was on the one hand rejecting her father aggressively and on the other hand, on a deeper level, submitting to him in a masochistic way. The disadvantage of the hypnotic treatment was clearly demonstrated by this failure to go on at a crucial point. However, the writer does not think in this case the aim should have been overstretched, considering the previous suicide attempt. The advantage of the course pursued was that the patient was ready for analysis when she left treatment and that the risk of suicide had diminished considerably.

It was found that the patient, having left the therapist after the seventh session, became mildly disturbed and remembered primal scene observations with her parents. In the writer's opinion, there could be only two possibilities here. First, a repressed memory may have been lifted in the hypnotic state and the material regarding her father's extramarital activities was found to be entirely unconscious. In this case the amnesia, it could be argued, had not been complete. Young[3] pointed out that suggestion and autosuggestion play such a role that one cannot speak of absolute phenomena in hypnosis. Bernheim did not believe in total posthypnotic amnesia. Strickler[4] found in experiments with nonsense syllables during and after hypnosis that no complete amnesia existed.

In this case, the lifting of the repression of traumatic events and their gradually becoming conscious in the following days could be the therapeutic agent. Psychoanalytically, the validity of this theory could be argued because of the uncertainty of real integration. Moreover, intellectualization takes place. Although this position can be taken, the writer feels that at least some, perhaps considerable, abreaction takes place.

On the other hand, we may deal with an entirely different defense mechanism: isolation. Brenman and Gill[5] point out that repression usually is lifted in hypnosis. The writer wonders whether we do not often deal with isolation, although it looks as if that which the patient tells us was forgotten.

The present patient, when relating the events reported here, used both past and present tenses and seemed to have been aware of the hypnotist's presence.

There is also the possibility that post-hypnotic amnesia is malingering and not simply an incomplete amnesia. The patient would be amnesic only to please the hypnotist (Pattie[6]).

If it were true that the therapeutic agent was the integration of isolated material, we could easily understand how hypnosis would work. A good and indulgent super-ego figure, to whom the patient could tell everything, would have been accepted. Following the confession, understanding and integration might take place.

An advantage of this viewpoint would be that so-called simulation or malingering would become more understandable. If it is isolation that is mainly used as a defense, we understand better why so many hypnotists get the impression that they are cheated by the patients. This explanation would, the writer believes, mean that in hypnosis a silent understanding sometimes exists between the patient and hypnotist, working together as a team. The therapist, as an indulgent, good parent, will listen benevolently, and will forgive and protect. In turn, the patient will be good and tell all.

It seems rather probable that both types of defense exist at the same time. In the preceding case, the writer felt that not all the material gained was repressed but that the lifting of isolation as an important defense was the main agent through which a therapeutic result was finally reached.

15 East 75th Street
New York 21, N. Y.

REFERENCES

1. Spiegel, H.; Shor, J.; and Fishman, S.: An hypnotic ablation technique for the study of personality development. Psychosom. Med., 7:273, 1945.
2. Róheim, Géza: The bear in the haunted mill. Am. Imago, 5:1, 71, April 1948.
3. Young, P. C.: The nature of hypnosis as indicated by the presence or absence of posthypnotic amnesia and rapport. J. Abnor. and Soc. Psychol., 22:372, 1928.
4. Strickler, Clinton B.: A quantitative study of posthypnotic amnesia. J. Abnor. and Soc. Psychol., 24:208, 1929.
5. Brenman, M., and Gill, M.: Hypnotherapy. International Universities Press. New York. 1947.
6. Pattie, F. A.: A report of attempts to produce uniocular blindness by hypnotic suggestion. Brit. J. Med. Psychol., 15:230, 1935.

INCIDENCE OF PULMONARY TUBERCULOSIS AMONG EMPLOYEES IN 14 INSTITUTIONS FOR THE MENTALLY ILL

BY JULIUS KATZ, M. D., ROBERT E. PLUNKETT, M. D., AND FREDERICK MacCURDY, M. D.

Material and Methods

A tuberculosis control program in the institutions of the New York State Department of Mental Hygiene was inaugurated in the fall of 1941 with the x-ray examination of all patients and employees in each of the institutions. These initial surveys brought to light hitherto unknown cases of pulmonary tuberculosis among both patients and employees.[1] Provisions were made for the segregation of patients with clinically significant pulmonary tuberculosis in separate buildings or in special wards. Employees with active tuberculosis were relieved from duty and referred to tuberculosis hospitals for further study and treatment. The present report covers 14 of the Mental Hygiene Department institutions.

To prevent the admission of unknown cases of tuberculosis among new patients and employees, routine x-ray examination of new patients at the time of admission and of new employees at the time of beginning employment was begun immediately after completion of the initial survey in each institution. As a result of these examinations, the pulmonary status of all patients and employees is known as of the time of the initial x-ray survey, or as of the date of admission or of the pre-employment film.

The control program also includes periodic x-ray re-surveys of all institutions. The data used in this report are based on the results of these re-surveys among employees of 14 institutions. The interval between the first and second surveys averaged about four years, but the periods between x-ray examinations in individual employees varied from a few weeks to almost five years.

There was no significant difference in the frequency of x-ray examination of employees on the tuberculosis wards as compared with those on other wards.

Eleven of the New York State mental hygiene institutions covered by this report are hospitals for mentally ill patients, while the other three are state schools for mental defectives. Eight of the hospitals and two of the schools have special wards or buildings for the care of tuberculous patients. The other three hos-

pitals and the other school have no such facilities, and transfer their tuberculous patients to institutions with tuberculosis wards. More institutions with facilities for tuberculous patients were selected for this report than institutions without these facilities, in order to obtain a sufficiently large group of employees who were occupationally exposed to tuberculosis.

Employees were considered as having newly-developed pulmonary tuberculosis only when the x-ray film showed evidence of clinically significant tuberculosis following one or more previously negative films. Those whose initial films were considered suspicious for reinfection tuberculosis, or showed changes interpreted as apparently healed tuberculosis or as pleural effusion, were not considered new cases of tuberculosis and were not included in this study. The survey films were 4″x5″ in size, but all final diagnoses of clinically-significant tuberculosis were made from 14″x17″ films. The diagnosis of tuberculosis was made by x-ray examination alone. In most of the cases, serial films, and/or reports of study during hospitalization in tuberculosis hospitals verified the diagnoses.

For the purpose of this report employees were divided into two groups according to whether they had any exposure to known cases of tuberculosis, as follows:

1. Employees having four weeks or more total time on duty in a tuberculosis ward. These are considered as having been occupationally exposed to tuberculosis.

2. Employees on duty in wards or buildings in which there were no known cases of tuberculosis, or who had less than four weeks of exposure.

During the period covered by this report, the average number of positions in the 11 institutions included was 9,996. These positions were filled by 22,072 individuals, for an average length of employment of 2.2 years.

Results

The incidence of pulmonary tuberculosis among employees is shown in Table 1. The total rates were higher among employees in the hospitals than among those in the state schools, 1.10 and 0.31 per 1,000 person-years respectively. Within each of these two groups, there was no significant difference in the total rate between males and females.

Table 1. Incidence of Pulmonary Tuberculosis Among Employees of 14 Institutions of New York State Department of Mental Hygiene

Institutions	All employees			Employees on Tbc. wards			Employees on other wards		
	Person-years	Cases of Tbc.	Rate per 1,000 Person-year	Person-years	Cases of Tbc.	Rate per 1,000 Person-years	Person-years	Cases of Tbc.	Rate per 1,000 Person-years
A. Hospitals*									
Total	33,701	37	1.10	1,346	10	7.43	32,355	27	0.83
Male	16,567	19	1.15	617	7	11.35	15,950	12	0.75
Female	17,134	18	1.05	729	3	4.12	16,405	15	0.91
B. Schools**									
Total	6,460	2	0.31	62	1	16.13	6,398	1	0.16
Male	2,488	1	0.40	8	..	..	2,480	1	0.40
Female	3,972	1	0.25	54	1	18.52	3,918	..	..
C. Hospitals and schools									
Total	40,161	39	0.97	1,408	11	7.81	38,753	28	0.72
Male	19,055	20	1.05	625	7	11.20	18,430	13	0.71
Female	21,106	19	0.90	783	4	5.11	20,323	15	0.74

*Binghamton, Central Islip, Harlem Valley, Hudson River, Kings Park, Marcy, Rochester, Rockland, Syracuse Psychopathic, Utica, Willard state hospitals.

**Letchworth Village, Syracuse State School, and Wassaic State School.

Among hospital employees the total incidence rate was 7.43 per 1,000 person-years among those working on the tuberculosis wards, as compared with 0.83 among those not exposed to known cases of tuberculosis among patients, a ratio of almost 9 to 1. The rate among exposed male employees was 11.35 per 1,000 person-years, that among the non-exposed 0.75. Among females the rates were 4.12 and 0.91 respectively. Thus, the rates were about 15 and five times as high respectively, among males and females employed on the tuberculosis wards of the hospitals as among those not thus exposed. These differences are statistically significant.

The rates among employees in the state schools, though based on smaller numbers, were also higher among those occupationally exposed to tuberculosis. Among those working on tuberculosis wards the rate was 16.13 per 1,000 person-years, while among those working on other wards, it was 0.16. The number of employees in the state schools and the number of cases among them are too small to be of statistical significance although the incidence rates show the same trend as among hospital employees.

Table 2 shows the incidence rate by age and sex. The total rate was 0.97 per 1,000 person-years. Among males the rates increased with age. Among female employees there was no definite correlation with age, though the rates were somewhat higher among those under 40 than among those above that age.

Table 2. Incidence of Pulmonary Tuberculosis Among Employees of 14 Institutions of the New York State Department of Mental Hygiene, by Sex and Age

	All employees			Males			Females		
Age	Person-years	Cases	Rate	Person-years	Cases	Rate	Person-years	Cases	Rate
Total	40,161	39	0.97	19,055	20	1.05	21,106	19	0.90
Under 20	2,135	1	0.47	642	..	..	1,493	1	0.67
20-29	9,137	8	0.88	3,488	1	0.29	5,649	7	1.24
30-39	10,548	7	0.66	4,978	2	0.40	5,570	5	0.90
40-49	10,122	6	0.59	5,112	4	0.78	5,010	2	0.40
50-59	6,220	11	1.77	3,485	8	2.30	2,735	3	1.10
60 and over	1,901	6	3.16	1,307	5	3.83	594	1	1.68
Not stated	98	..	..	43	..	..	55	..	..
Under 40	21,820	16	0.73	9,108	3	0.33	12,712	13	1.02
Over 40	18,243	23	1.26	9,904	17	1.72	8,339	6	0.72

These age-specific differences in incidence rates are probably not related to occupation, since among male employees they were higher in the older age groups regardless of occupational exposure, as shown in Table 3. This table shows that among male employees on the tuberculosis wards, as well as those working among nontuberculous patients, the incidence rates were higher after 40. Among females there was no difference in incidence rates in the two age groups among those employed on the tuberculosis wards, while among those not working on tuberculosis wards the rate was somewhat higher among those under 40.

Table 3. Incidence of Pulmonary Tuberculosis Among Employees of 14 Institutions of New York State Department of Mental Hygiene by Age, Sex and Occupational Exposure

	Total			Male			Female		
Age	Person-years	Cases	Rate	Person-years	Cases	Rate	Person-years	Cases	Rate
A. Employees on tuberculosis wards									
Total	1,408*	11	7.81	625*	7	11.20	783*	4	5.11
Under 40	675	2	2.96	281	..	..	394	2	5.08
Over 40	723	9	12.45	339	7	20.65	384	2	5.21
B. Employees on general wards									
Total	38,753**	28	0.72	18,430**	13	0.71	20,323**	15	0.74
Under 40	21,145	14	0.66	8,827	3	0.34	12,318	11	0.89
Over 40	17,520	14	0.80	9,565	10	1.05	7,955	4	0.50

*Includes 10 with age not stated—5 males, 5 females.
**Includes 88 with age not stated—38 males, 50 females.

Further study is needed to determine the relationship between age and tuberculosis incidence rates, particularly among males, since data being collected in New York State tuberculosis hospitals relative to incidence rates among employees suggest that the rates are higher among younger employees than among older ones, findings exactly the opposite of those obtained in this study.

The incidence of tuberculosis by type of occupation is shown in Table 4. The rate was 0.97 per 1,000 person-years for all employees. Employees on the tuberculosis wards had an incidence rate of 7.81 as compared with 0.72 among those working on other wards. The rates for attendants and nurses on the tuberculosis wards were essentially the same, 7.75 and 8.26 respectively. Both these rates were much higher than among employees doing similar work among non-tuberculous patients (0.88 among attendants

and 0.67 among nurses). The numbers of physicians and laundry workers were too small for the rates to have any statistical significance.

Even on the general wards of the institutions the incidence rates among employees providing direct service to patients, such as attendants, nurses, physicians, and laundry workers, were higher than among employees in less direct contact with patients, the rate being 0.88 per 1,000 person-years for the former group, and 0.41 for the latter. This difference is probably due to exposure to cases of tuberculosis which develop between the routine periodic chest x-ray surveys made in these institutions. This is discussed further in this paper. Among employees on the tuberculosis wards, no such difference in incidence rates exists, since employees in both groups are occupationally exposed.

Among male employees, in 14 cases the disease was diagnosed in the minimal stage; in five it was moderately advanced; and in one far advanced. Among the females, all 19 were minimal.

Discussion

For the proper evaluation of the incidence rates, and the occupational hazard among employees in mental institutions, comparisons should be made to determine, first, whether tuberculosis incidence rates among those not employed on the tuberculosis wards are higher than among groups similarly employed, but among mentally normal patients, or in occupations considered to be free from tuberculosis hazard; second, whether the rates among employees on the tuberculosis wards are excessive as compared with groups caring for mentally normal tuberculous patients. Unfortunately the literature on tuberculosis incidence rates is scanty, most studies reported being concerned with student nurses.

An incidence rate of 1.0 per 1,000 annually among 3,000 hospital porters, maids, and attendants observed over a period of three and one-half years was reported by Brahdy.[2] Kramer, Comstock and Stocklin[3] reported an annual incidence rate of 0.89 per 1,000 employees in an industrial plant. Reid[4] reported an annual incidence rate of 2.2 per 1,000 male and 2.51 per 1,000 female employees of the Metropolitan Life Insurance Company. The rate had declined from 4.0 per 1,000 in 1930 to 1.0 per 1,000 in 1939. While these reports do not give sufficient information for comparison regarding economic status, age, and sex distribution of the

groups studied, there is no reason to believe that these factors are sufficiently different from those among employees of mental institutions to affect the tuberculosis incidence rates materially.

There is little information regarding the tuberculosis incidence rate in the general population. However, an estimate of this rate may be made from the number of cases of tuberculosis reported annually. While the cases reported in any given year do not necessarily represent those that develop during that year, nevertheless, over a period of time, the number reported may be considered an approximation of the rate of development of new cases. The case-finding activities of the past few years undoubtedly have affected the number of cases diagnosed, but the reported case rates have not yet been materially changed in upstate New York as shown by the following table. This table shows the reported case rates per 1,000 population 15 years of age and older in upstate New York for the past eight years; a period which corresponds approximately to the period during which the 14 institutions were surveyed:

1941	0.98
1942	1.16
1943	1.12
1944	1.00
1945	0.88
1946	1.00
1947	0.95
1948	0.95
Average	1.00

Since these are annual rates, they may be compared with the incidence rates cited from the literature and with those obtained in this study.

The tuberculosis incidence rate of 0.72 per 1,000 person-years among all institutional employees not working on the tuberculous wards compares favorably with the rates mentioned in the three reports cited, and in the general population, and indicates the absence of any unusual tuberculosis occupational hazard involved in the care of these mental patients as compared with similar occupational groups among mentally well patients or even when compared with groups among which there is no known special tuberculosis hazard.

It was pointed out in the foregoing that employees, such as attendants and nurses, providing direct service to patients on the general wards had higher incidence rates than those providing less direct patient service, such as clerks, maintenance workers, and others. This would seem to contradict the foregoing statement that there is no unusual occupational hazard involved in the care of mental patients on these wards. There is, of course, danger of developing tuberculosis as the result of contact with patients among whom sporadic cases of infectious tuberculosis develop which are not detected for considerable periods. This is probably the cause of the higher rate among attendants and nurses. However, this danger is not limited to employees in mental institutions. The different rates among employees of mental institutions were obtained because of the subdivision of employees into those in close contact with patients and those not in such contact. If *any* group of employees were separated into two groups, those whose occupation includes contact with tuberculous individuals, and those who are not subject to such exposure, it is to be expected that the former group will have higher incidence rates. Since Table 4 makes this distinction, the difference in rates is not unexpected. The fact that the *total* incidence rate for employees on the general wards of these institutions is essentially the same as that obtained among other occupational groups indicates that there is no excessive occupational hazard among these employees.

The study by Lim-Yuen[5] of incidence rates among employees of the Manitoba Tuberculosis Sanatorium may be used for comparing the relative hazard among employees on the tuberculosis wards of mental institutions with that among employees caring for mentally normal tuberculous patients. This study, covering the six-year period from 1938 through 1943, showed an annual morbidity rate of 18 per 1,000 for the entire group of 559 employees. The rate among employees beginning work in the sanatorium with negative tuberculin reactions was 38 per 1,000 per year, while that among positive reactors was 8.9 per year. Since the writers' records indicate that most employees of mental hospitals in New York State have positive tuberculin reactions upon beginning employment, particularly those 40 years of age or older, the latter rate

Table 4. Incidence of Pulmonary Tuberculosis Among Employees of 14 Institutions of New York State Department of Mental Hygiene by Occupation, Sex and Type of Ward

	All wards			Tbc. wards			Exclusive of Tbc. wards		
	Person-years	Cases	Rate	Person-years	Cases	Rate	Person-years	Cases	Rate
All employees—total	40,161	39	0.97	1,408	11	7.81	38,753	28	0.72
Male	19,055	20	1.05	625	7	11.20	18,430	13	0.71
Female	21,106	19	0.90	783	4	5.11	20,323	15	0.74
Attendants—total	20,401	25	1.23	1,032	8	7.75	19,379	17	0.88
Male	8,998	14	1.56	503	6	11.93	8,495	8	0.94
Female	11,403	11	0.96	529	2	3.78	10,884	9	0.83
Nurses—total	3,208	4	1.25	242	2	8.26	2,966	2	0.67
Male	546	1	1.83	53	1	18.87	493	..	..
Female	2,662	3	1.13	189	1	5.29	2,473	2	0.81
Physicians—total	725	1	1.38	21	..	..	704	1	1.42
Male	651	..	..	20	..	..	631	..	..
Female	74	1	13.51	1	..	..	73	1	13.70
Launderers—total	931	1	1.07	3	..	..	928	1	1.08
Male	315	1	3.17	..	..	..	315	1	3.17
Female	616	..	..	3	..	..	613	..	..
Attendants, nurses, physicians and launderers—total	25,265	31	1.23	1,298	10	7.70	23,967	21	0.88
Male	10,510	16	1.52	576	7	12.15	9,934	9	0.91
Female	14,755	15	1.02	722	3	4.16	14,033	12	0.86
Other employees—total	14,896	7	0.47	110	1	9.09	14,786	6	0.41
Male	8,545	4	0.47	49	..	..	8,496	4	0.47
Female	6,351	3	0.47	61	1	16.39	6,290	2	0.32

is more suitable for comparative purposes. This rate of 8.9 per 1,000 per year is not appreciably different from the rate of 7.4 per 1,000 found in this study among employees exposed to tuberculous mental patients, and indicates that there is no significantly excessive occupational hazard due to the concurrent presence of tuberculosis and mental disease.

Conclusions

1. The danger of development of occupationally-acquired tuberculosis by employees on the general wards of mental institutions is apparently no greater than that by those similarly employed in other hospitals, or in occupations with no known tuberculosis hazard.

2. The tuberculosis incidence rate among employees on the tuberculosis wards is higher than among employes on the other wards of these institutions.

3. The frequency of development of clinically-significant tuberculosis by employees on the tuberculosis wards in mental institutions is probably about the same as that among employes of hospitals for mentally-well tuberculous patients.

4. The results of this study indicate that the phases of the tuberculosis control program in mental institutions which need emphasis are as follows: a. To decrease the relative number of employees exposed to tuberculous patients, the concentration of these patients in a few tuberculosis centers, should be accelerated. b. Employees on tuberculosis wards should be kept under close medical observation with frequent, periodic chest x-ray examinations. c. Training in infectious disease techniques should be given to all nurses, attendants, and other employees working on tuberculosis wards.

New York State Department of Health
Division of Tuberculosis Control
Albany Garage Building
Albany 7, N. Y.
and
New York State Department of Mental Hygiene
Gov. Alfred E. Smith State Office Building
Albany 1, N. Y.

REFERENCES

1. Katz, J.; Plunkett, R. E.; and Thompson, M. E.: Prevalence of pulmonary tuberculosis in New York State institutions for the mentally ill. PSYCHIAT. QUART., 19: 4, 664, October 1945.
2. Brahdy, L.: Tuberculosis in hospital personnel. J. A. M. A., 114:102-106, January 13, 1940.
3. Kramer, M.; Comstock, G. W.; and Stocklin, J. B.: An evaluation of a chest x-ray resurvey of an industrial plant. Public Health Reports, Vol. 61, No. 27, July 5, 1946.
4. Reid, A. C.: Control of tuberculosis. II. Pulmonary tuberculosis in employees. J. Indust. Hyg. and Toxicol., 22:408-415, November 1940.
5. Lim-Yuen, D. M.: Tuberculosis in sanatorium personnel. Am. Rev. Tuberc., 54: 261, September 1946.

EDITORIAL COMMENT

PATTERN FOR EVIL

The leaders of the resistance are executed one by one. The children of the conquered are torn from their parents to be trained in new ways. Forced labor is instituted. There is general spying and lying. Books are burned and those who are learned are forbidden to teach the new generation to read the old writings. Priests are hounded; scientific teachings are proscribed; there is general hunger and starvation: there are mass suicides among men of military age.

It was the Preacher of *Ecclesiastes* who observed (Ecc. 1. 9.): "The thing which has been is that which shall be; and that which is done is that which shall be done; and there is no new thing under the sun."

There are new techniques and a new technology, the Nazi gas chamber, the Communists' drug-addiction; but however new the techniques, there is nothing new in the general pattern; the general pattern of oppression is as old as the first oppressor who ever walked under the sun. And the report with which this discussion began is no tale of today or even recent yesterday; it is from the book of Chilam Balam, the jaguar priest, of Tizimin, written two centuries ago about events two more centuries before*; and it is cited here because the events it chronicles come as near as anything in recorded history to achieving the present aims of Communism, the complete destruction of all variant cultures, their science, their literature, all their written records, even the memory of their freedom.

The Conquistadors who followed Cordoba into Yucatan not only set out to enslave a free people but to change their ideology to the point where they would willingly accept bondage. One can see precisely comparable processes at work today in Czechoslovakia, Poland, the Baltic states and other occupied nations, glimpsed through the iron curtain. When the jaguar priest of Tizimin set down—or more probably dictated to a scribe who knew the Latin

*The Book of the Jaguar Priest. Maud Worcester Makemson, translator and commentator. 238 pages with interpretive commentary and index. Cloth. Schuman. New York. 1951. Price $3.50.

alphabet—his reading, and doubtless personal interpretation, of the ancient hieroglyphs, he was reading a manuscript whose destruction had been ordered two hundred years before. It was a pitiful remnant of the Maya people's books of history and science, burned publicly by the "strutting turkey cocks" who overthrew and enslaved them.

When the Spaniards completed the military conquest of upper Yucatan in 1546, their armies set out to confiscate all the material possessions of the defeated Maya; and their priests set out to destroy all vestiges of Maya culture, under the natural persuasion that the sacred books of the jaguar priests, and all their technology and science, were works of the devil. One may wonder if in all history there is a parallel record of such a successful attempt to destroy a culture and all its attributes. The Achean heroes of whom Homer sung so destroyed the great empire of Minoan Crete, but there is every reason to think the result was incidental to warfare, not deliberate. The Hyksos kings, lured into the valley of the Nile by visions of "corn in Egypt," are said to have aimed at the extirpation of the Egyptians; but the Hyksos fled, their monuments dust and their Pharaohs' names forgotten, before the rise of a new and mighty Egyptian empire. When Egypt finally fell, when Greece fell, when Rome fell, their stories lived on.

When the Communists completed the conquest of Czechoslovakia, of Poland, of Bulgaria, of China (one may fill in with whatever name one pleases), they proceeded word by word and letter by letter as had the men of Castile and Leon in Yucatan. One may forecast the ultimate objective accurately from George Orwell's nightmare novel, *Nineteen Eighty-four,* in which history is systematically destroyed or distorted to fit the past, not into the pattern of what was, but into the pattern of what ought to have been —to justify whatever the party line of the present might require.

One might cite, again from Egypt, the tale of the fabulous Queen Hatshepsut, under whose reign Egypt explored, built monuments and was laden with treasure, like England under Elizabeth. Her stepson successor, the great conqueror Thutmosis III, chiseled her name from her obelisks and temples, and the later priests and rulers joined in obliteration of her records. But the story of her exploits remains, perhaps the greater for her successors' vindictiveness.

So too lived on, they who sat by the rivers of Babylon and wept when they remembered Zion, and their children and children's children through millenia of ancient and modern oppression—to rebuild the most ancient of the western world's nations after massacre, concentration camp and gas chamber. The scroll is long of the names of the nations who have survived centuries of tyranny—Poland, China, Finland, Serbia, Greece.

In Lord Dunsany's never-land of Runazar—he records in *The Book of Wonder*—lived a king whose insolence so angered the gods of Pegana that they decreed he was not and never had been. And "the land of Runazar hath no king nor ever had one."

Possessed of the atom bomb or not, the Marxian lords might envy the gods of Pegana. This that is so, is not; this that has been, never was—but truth by fiat passes currency for scientific truth only within the lands ruled by the Kremlin. Elsewhere, for the most part, the facts of genetics, food chemistry and astrophysics are determined by careful inquiry and statistical evaluation, not Marxian pronouncement.

Just how we would be able to inquire into and study such matters under world Communist rule—which is not at all—we may infer from what we can learn of the present fate of education, science and thought in Poland, Czechoslovakia and even Russia itself. For the emotional state—the despair, the lamentations, the hopelessness—of a people under this sort of rule, we can do no better than to refer once more to the fragmentary records of the various Chilam Balam of Tizimin, as compiled in *The Book of the Jaguar Priest*. We have long been familiar with the sad story of the failure of Roman government, Roman peace and Roman technology, with the plunging of the western world into anarchy, ignorance and physical misery. What is recorded in *The Book of the Jaguar Priest* is that and something else; it is the destruction, as well, of a people's learning, of its educational system, its religion, its written communications, its way of thought. As the complete accomplishment of a program, it has lessons not readily derived from a program we merely see in progress. Any psychologist with a mystical turn can envision it as the destruction of the soul of a people; it is a record of sorrow well worth the study of any who are not yet convinced that we are in danger of losing our own.

A LITTLE RED LIGHTHOUSE

The world's great minds have pondered the matter for some thousands of years; and one of America's better-known psychiatrists once devoted a book to the problem; but nobody has yet developed a really satisfactory formula for how to be happy though human.

The basic difficulty is to reconcile the inevitable mediocrity, anxiety and frustration of the generality of man with his longings for achievement, security, affection and accomplishment. Not to discuss the inner dynamics, concerning which one may, like Omar, "eagerly frequent" Doctor and Sage and hear great argument, man has from time out of mind overtly sought ways to make friends with a hostile world and a human society too often hostile to the individual.

Medicine man, witch and wizard cast spells and made conjurations against storm and torrent, wild beast and evil spirit; priest and priestess made human sacrifice to bloody storm god and bloodier earth goddess. Through the ages, general happiness and security have remained aspirations, not achievements; and man's fertile mind has devoted as many expedients to reconcile him to the situation as to efforts to improve it. From time immemorial, for example, the unscrupulous have sought to use religion improperly to keep men quiescent. Our own grandfathers saw un-Christian use of Noah's drunken curse on Canaan to justify Negro slavery and persuade the slaves themselves that they deserved what was coming to them. Sometimes such comfort was thin. One can remember the anarchistic I. W. W. "Wobblies" who, after World War I, sang sarcastically, "Work and pray, live on hay, You'll get pie in the sky when you die." And sometimes, the non-religious have seriously applied the technique. That there will be pie (not in the sky) for children or grandchildren is the first article of faith for the atheistic martyrs of the proletarian revolution.

Our children have generally fitted, more pitiably than our adults, into this picture. One seldom finds a child—who understands what is being talked about—who can be persuaded that it is very good to be an unhappy child, if afterward one can be a happy little angel. So, since pithecanthropic time ended and human time began, there have been special efforts—grown people, after all, having some bowels of compassion—to find ways to teach chil-

dren to be happy though human. There have been folk tales, fables, parables and fairy tales. They go something like this:

Life is good to good children. The good animals are rewarded, why not good children? If one acts like the good little match girl, one may freeze to death but surely will be happy ever after. And in the worst straits, there are always fairy godmothers. The chief things wrong with this story are that life often seems to be particularly good to the bad children; that all that is certain about the little match girl is that she was frozen to death; and that fairy godmothers seldom materialize during the worst spankings.

So, very recently—that is, in the last few centuries—there have been efforts where children are concerned to temper and adapt promises of happiness. We eliminated the fairy godmother from the good things which happened to good children, but we also eliminated most of the horrors from the bad things which happened in any event to good children; and we added the "moral," a little distortion which led to the conclusion that evil was always punished and virtue always rewarded by health, wealth and living happily ever afterward. Since this isn't so, has never been so, and couldn't conceivably be so in any human society we can now imagine, we have since changed the tale once more and still once more.

Virtues which appeared to be rewarded for a while, those of Tennyson's Victorian knights of King Arthur's table round, of Kipling's British empire-builders, of Henty's noble young heroes, of Horatio Alger's hard-working, honest, frugal souls, may still be worth cultivation, but are of unclear practical utility in a world of supersonic speeds, nuclear fission and U. N. diplomacy. We are still emphatically in favor of goodness for its own sake; but few reasonably alert children could be sold today on the idea that the cash returns are what they used to be cracked up to be.

And so we come to the tale of a great big bridge and a little red lighthouse, a tale titled, when it appeared nine years ago, *The Little Red Lighthouse and the Great Gray Bridge*. It was a story, whether so intended by its author, Mrs. H. H. Swift, or no, made to order for the mental hygienists. Steering skillfully between the impersonal machinery by which Horatio Alger punished the wicked and rewarded the good boys of this world, and the whirlpool where all is lost save the hope of pie in the sky, Mrs. Swift pointed to the little lighthouse as an example of the use and value of small things in a world of overwhelmingly big ones.

Here was security for her readers; the little red lighthouse on the Hudson shore had been overcome with worry and anxiety when it first was overshadowed by the George Washington Bridge; in the end, it learned that it still had useful purposes to fulfill, valuable things to do. Here was fine mental hygiene—without fairy godmother rewards or excessive resignation to fate—until the United States Coast Guard decided it didn't need the little red lighthouse any more.

There was a fine to-do, we are glad to say, with *The New York Times* and New York's children leading a campaign like the one inspired by Oliver Wendell Holmes that saved the frigate *Constitution*. It looks, now, as if the little red lighthouse may be around to delight children and point its cheerful moral for some years to come.

But what we are concerned about here is whether the little red lighthouse is really nearly enough permanent to draw a moral from. And if it isn't, what is? An island versus the mainland? Manhattan versus the Catskills or the Ramapos? But a little more sun on the polar ice caps, a couple of hydrogen bombs, or a new bacterium—and where is the metropolis of yesteryear? From the geological point of view, what is even permanent about a continent —Appalachia, Lemuria?

One supposes there is a certain relative permanence about the sun; it is likely to be blazing happily away several billion years from now, before it finally expands, explodes, or the planets fall into it. Perhaps one could point a moral in a story entitled *The Little Yellow Sun and the Great Big Galaxy.* It would be the tale of our sun, an undistinguished star who felt bad because he wasn't so bright by 100 times as Arcturus or by 10,000 as Rigel, who was sad because he had no companion to play with like Mizar or Capella, or couldn't wink—now bright, now dim—like Mira Ceti. But our undistinguished sun raised (or, according to Hoyle, adopted) a very fine family of flourishing plants, of which at least one has the blue sky, the glistening ice caps, the sparkling oceans and the green lands of the earth we live upon. Here is a fine and improving story of the secure place of a small thing in a universe so great that our minds fail to imagine the vastness from star system to star system, to what we have to call—for inability to comprehend—the outermost galaxy.

But somehow we cannot see a material improvement in child behavior or any important increment to child happiness in a fairy story about our poor little sun finding he could be useful and happy, if insignificant. And we see no point in the present state of human knowledge in trying to find anything significantly nearer permanence. We are moved to wonder, in fact, if in the childish wave of consternation which followed the threat to destroy the little red lighthouse, there is not something to point still a further moral for the mental hygiene Sheharazades. If fairy tale omnipotence is a bad idea because dreams of omnipotence are impractical and lead to camisoles and suicides, dreams of immortal permanence have led to living abominations like Medea and Giles de Rais.

Might it not, in addition to setting children's tales of achievement within the non-frustrating limits of accomplishment, be well to set them also in practical temporal limits? In the scale of time, man is less like the galaxies, less like the sun, less like the islands and the continents, than like the mist before the sun, the cloud before the wind, or the drifting butterfly. All things pass, man sooner than most. *Ça ira!*

BOOK REVIEWS

S. Weir Mitchell. By ERNEST EARNEST. vii and 279 pages. Cloth. University of Pennsylvania Press. Philadelphia. 1950. Price $3.50.

S. Weir Mitchell had no better press agent than S. Weir Mitchell. While announcing to the world that he was at least a genius, he went far toward proving it. His methods in the treatment of emotional disorders are antiquated today, but it must be remembered that he was working in an age of different mores from those now in force. He was almost always ahead of, rather than behind, his contemporaries, and he cannot be condemned for not being completely "modern." This biography helps to explain the man in relation to his environment—a human figure and not a museum piece to be typed, classified, stored away, and forgotten.

Sex Offenses. The Problem, Causes and Prevention. By MANFRED S. GUTTMACHER, M. D. 159 pages including index. Cloth. Norton. New York. 1951. Price $2.50.

This is a sane and authoritative, but unfortunately not exhaustive, book. Psychiatry and transgression of the law presumably have their greatest common meeting ground in the field of sex offenses. This book is based on the fourth series of the Jacob Gimbel Lectureship on Sex Psychology sponsored by Stanford University. The author is a widely-known authority in the field and is chief medical officer of the Supreme Bench of Baltimore. His point of view is psychoanalytic or perhaps neo-Freudian.

These lectures cover the prevalence of the problem, its clinical aspects, treatment and prevention. Here is where one might well wish that the book were more comprehensive. Dr. Guttmacher cites, for instance, the work of Dr. Newdigate Owensby in the reported successful treatment of homosexuals with metrazol, and that of Anna Freud, but he omits mention of the very extensive work of Edmund Bergler. The book is nevertheless excellent orientation for any psychiatrist interested in the legal aspects of this problem, and should be useful to any general practitioner in contact with cases of sexual perversion.

Conjugal Love. By ALBERTO MORAVIA. 183 pages. Cloth. Farrar, Straus and Young. New York. 1951. Price $2.50.

A woman and her ability to have strong feelings of conjugal affection and at the same time be influenced by intense sexual drives set the pattern for this novel. The characters are at a minimum and the novel is short—seeming much shorter than it actually is because of the smoothness and continuity of the action. It is a book to be read in one evening; and one may count on finding the evening enjoyable.

Encyclopedia of Superstitions. By EDWIN and MONA A. RADFORD. 269 pages including bibliography. Cloth. Philosophical Library. New York. 1949. Price $6.00.

The dust jacket of this book indicates inaccurately that it is an attempt to cover completely superstitions which exist or have existed among people throughout the world. The authors' preface, however, makes it plain that the subjects covered are primarily British with notes from abroad only when similarity of subject exists. American superstitions have been enriched by contributions from Ireland, Germany, France and elsewhere but the bulk of our superstitious beliefs can probably still be referred to British sources. References will be found here from accidents, acorns and adders, through the Hand of Glory, rats and red thread, to the yew tree and usefulness. This is a useful and important work for all who are interested in popular irrationalities.

Don Quixote. By MIGUEL DE CERVANTES SAAVEDRA. Translated by J. M. Cohen. 940 pages. Paper. Penguin Books. Middlesex. 1950. Price 5/—.

Cervantes' *Don Quixote* is beyond doubt the greatest tale of madness in fiction. Readers of English have suffered in the past from cumbersome, poorly-translated or badly-phrased versions. J. M. Cohen has rendered it into smooth, modern English without destroying the archaic flavor. This low-priced Penguin edition is in clear print and readable format. It can be recommended to all psychiatric readers unfortunate enough to lack copies of this classic in their personal libraries.

Standard Dictionary of Folklore, Mythology and Legend. Volumes 1 (A-I) and 2 (J-Z). Maria Leach, editor. 1196 pages. Cloth. Funk & Wagnalls. New York. 1949 and 1950. Price $7.50 per volume.

The first volume of this work was published in 1949. At that time the reviewer for this QUARTERLY noted that it had prospect of becoming a "standard and virtually indispensable reference work for students of the sciences of mankind." Volume 2, which completes the text with references from J through Z, amply bears out this prediction. The articles are well condensed and well presented and are as authoritative as they could well be made.

Students have long recognized that the mental aberrations of the individual have their counterparts in the folklore of the race. This dictionary is a work, therefore, which should be as useful to psychiatrists as to any other social scientists.

When volume 1 was published, a third volume, to contain an index, was announced. For the person not acquainted with motif phraseology, this third volume should be an invaluable addition.

The classification of folklore is esoteric and the student of the cognate sciences will find the present two volumes, useful as they are, limited by the extent of his own understanding of the accepted system. Given the promised index, it should be possible for the uninitiated to locate much material now covered adequately but difficult to find without knowing the classification system.

On the Nightmare. By ERNEST JONES. 373 pages. Cloth. Liveright. New York. 1951. Price $4.95.

Ernest Jones has analyzed the nightmare and related it to eroticism. The theory held is that the more normal to the person the sexual drive portrayed in a dream, the more realistic the representation of the fulfillment will be. As the drive becomes more unacceptable to the conscious, it becomes overlaid with feelings of fear, and this is portrayed in the dream by an increasing anxiety (*Angst*), a further removal from reality, and an increasing use of symbolism to portray wish fulfillment. On this basis the classic nightmare, with its feelings of total panic, chest pressure and breathing difficulty, and complete paralysis is held to be the result of a repressed incest desire—the most inadmissable to the ego of all drives. The pleasurable fulfillment has been submerged under the anxiety.

Many of the objects of superstition prevalent in the Middle Ages, and still adhered to by some today, are shown in their relationship to the nightmare and other dream images. "Incubation," the vampire, the devil, the werewolf, and the witch are studied and their interrelationships shown. Only a confirmed Freudian can accept all the conclusions drawn, but the need for students of folklore to have a knowledge of dynamic psychology to implement their research is again demonstrated. The book is logical, well written, and extremely interesting, but this reviewer wishes a translation of the extensive French and Latin passages had been supplied—assuming a knowledge of these languages may have been justified when this book first appeared in 1910, but is hardly justified today.

The True Believer. By ERIC HOFFER. 176 pages. Cloth. Harper. New York. 1951. Price $2.50.

Eric Hoffer is a Pacific Coast longshoreman. He notes on the dust jacket: "I had no schooling," but his reading has been wide and extraordinary.

His vivid and astonishing book is a description rather than a dynamic analysis of the true believer who makes up in numbers the backbone of fanaticism. The professional student of psychodynamics may quarrel with some of his assumptions but hardly with his general insight. The reviewer thinks this book will help anybody understand how people become fascists, communists or religious fanatics. It can be recommended for general reading.

Fundamentals of Social Psychology. By EMERY S. BOGARDUS. 530 pages. Cloth. Appleton-Century-Crofts. New York. 1950. Price $4.50.

In the preface to the fourth edition of this textbook, the author tells us, "The major subject matter of social psychology is now generally considered to be the field of social forces within groups that play upon the members and between groups that play upon the groups themselves." In other words, this book should deal with the psychological reasons behind social interactions between individuals and between groups of individuals.

The book is divided into four approximately equal sections. Part I, "Behavior and Personality," discusses the origins of behavior in inherited nature and in conditioned response patterns; gives brief consideration to behavior as it acts and as it controls, and to the conditioning of this acting and controlling into attitudes; declares that the intergradation of these attitudes constitutes the essence of personality; investigates the effect of this personality on others and the status it creates; and, finally, presents the way the integrated attitudes we have form a configuration of the total personality.

Part II, "Behavior and Leadership," defines leadership from a sociological viewpoint, and gives examples of such factors as originality, talent, and genius; discusses the difference between invention and discovery; and goes into what is leadership, how autocratic leadership is different from democratic, and what are the problems of leadership.

Part III is called "Interaction and Process." This deals with social intercourse between personalities. At this point, communication, discussion, suggestion, fashion, custom, conflict, accommodation, assimilation, and socialization are gone into somewhat superficially although at some length.

In Part IV, "Interaction and Group Life," the author states, "Social interaction always takes place within or between groups." In discussing this he gives the sociological construction of primary groups, secondary groups, mobs, crowds, assemblies, publics and occupational publics. He then presents the rudiments of such social phenomena as group loyalty, group morale and social controls. The book ends with a brief history of social psychology.

Some readers may get the impression that subject matter has been sacrificed somewhat for simplicity. The style appears to be directed at the high school level although there may be those who will feel it a little too wordy for this age group. The general orientation seems to be more sociological than psychological.

Social Anthropology. By J. S. Slotkin. 598 pages. Cloth. Macmillan. New York. 1950. Price $4.75.

This appears to be a textbook for the beginning student in the social studies. The subject matter is much the same as that of general sociology. The approach differs, in that it is basically a comparative study of human societies and cultures.

The author starts with the premise that adjustment to the environment is the goal of all animal behavior, the motivation for which behavior is maladjustment. With this in mind, he defines society and social interaction and discusses custom and culture. He classifies customs as follows: "I. Approaches to Environment; A. Naturalism, B. Supernaturalism, C. Estheticism, D. Mysticism"; "II. Economy"; "III. Communication"; "IV. Social Organization"; "V. Social Control."

The theories and practices of each approach to the environment are discussed in terms of different cultures. Generally speaking, Dr. Slotkin finds naturalism provides society with its sciences and technology; supernaturalism makes up its dogma and ritual; estheticism gives it its art and play, while mysticism organizes all immediate experiences in terms of whatever has highest value or, as he states, ". . . it changes an individual's experiences rather than modify the environment itself . . . in mysticism a man adjusts by rapture. . . ."

These are approaches to the environment; the things used in adjustment by these approaches, the rights connected with these things, and the distribution of them, constitute the economy of a society. This, plus communication (signs and symbols of a culture), the author deals with in terms of many societies.

The author finds collective action is brought about by a "body of customs through which people are correlated and their behavior coordinated. . . ." Social organization, he states, involves how people are related (kinship, locality, biological characteristics, interest, and congeniality) and how their behavior is co-ordinated (politics).

Dr. Slotkin considers that the behavior of participants in a culture is regulated by a body of customs called social controls. These are education, reinforcement by interdependent customs, and sanctions, or rewards and punishments. The first are teachers; the latter are enforcers.

This book is written at the sophomore college level. As a textbook, it has the advantages of an interesting style and continuity of thought and purpose throughout. It contains as much information as the average sociology textbook, but, also like sociology texts, it is rather long in words. It seems pertinent to mention that more than one-half of the book is devoted to quotations from writings on, and statements from, cultures, including our own, used for illustrative and comparative purposes.

Kierkegaard, the Melancholy Dane. By H. V. MARTIN, M. A., B. D., Ph.D. 119 pages. Cloth. Philosophical Library. New York. 1950. Price $3.00.

Sören Kierkegaard devoted much of his writings to the essential paradoxes of life and of the Christian religion. He himself, and the ideas built up around him illustrate another paradox; a man who may be revered by some as a religious thinker, by others as a mystic, and be held by yet others as one of the founders of the Existentialist movement—the movement whose basic concept is man adrift upon an essentially hostile, changing universe.

Himself of the ministry, Dr. Martin has treated Kierkegaard from an entirely religious point of view. Believing that much modern religious thought springs from Kierkegaard, he has attempted to make his philosophy clear, especially the sense of complete guilt before God and the "truth of subjectivity." This book is an analysis of the thoughts of Kierkegaard and not of the man Kierkegaard, and of what led him to develop those thoughts. His great love of his father and the emotional shock he received when the discovery was made that his father married his mother only to preserve her good name are brought out, but gone into in no detail.

Introduction to a Psychoanalytic Psychiatry. By PAUL SCHILDER. Translated by Bernard Glueck. 174 pages. Cloth. International Universities Press. New York. 1951. Price $3.25.

This is a reprint of Schilder's pioneer book, first published in 1926. Schilder was an independent thinker; he was the opposite of an adherent to any type of orthodoxy. His use of analytic precepts is eclectic; his vision was remarkable. The whole book is rather an outline; since its first publication many newer and more detailed books have appeared. Still, Schilder's work is still worth reading and studying. It is even today more than a historical document.

The Personality of William Harvey. By GEOFFREY KEYNES. 48 pages, 8 portraits. Cloth. Cambridge University Press. New York. 1949. Price $1.00.

The works of many early medical men are known to all through their writings and the writings of others; the same cannot be said for their personalities. Dr. Keynes has attempted to bring out, from contemporary evidence and portraiture, the personality of William Harvey, the distinguished physician and physiologist who first developed the true concept of the circulation of the blood. By far the most interesting portion of the book is the evaluation and photographs of the portraiture, the scantiness of reliable contemporary writings on Harvey effectively preventing any deep study of his personality. The authenticity and importance of all of the portraits and reputed portraits are discussed, and a new, not previously-known painting, done in Harvey's younger life, is brought forward.

Kierkegaard. By RUDOLPH FRIEDMANN. 68 pages. Cloth. New Directions. New York. 1950. Price $1.50.

In this brief essay, Rudolph Friedmann analyzes the philosopher, Kierkegaard. His biography is highly provocative, and is based on the evidence about the thinker's life as revealed in his writings. Friedmann arranges his little book in two parts: Part I deals with "the classical Kierkegaard type and the epigone," and Part II concerns "the analysis of the psychological personality." The book contains both a glossary and a chronological table of Kierkegaard's life.

Despite its brevity and omissions, this is a significant contribution to the literary and psychological criticism of Kierkegaardian thought. As the author points out, Kierkegaard is of special interest to psychologists as a type who contained within himself the power to ascend to the utmost peaks of individuality, "even before the dawn of analytical consciousness." Friedmann presents an interesting statement and viewpoint on the all-important subject of type-psychology.

Speech Therapy for the Physically Handicapped. By SARA STINCHFIELD HAWK. 245 pages. Cloth. Stanford University Press. Stanford, Calif. 1950. Price $4.00.

Current interest in the cerebral palsied child underlines the need for aid to all speech defectives or physically handicapped children. Each day new contributions of research confirm our knowledge that successful therapy for the speech defective must include psychological and psychiatric as well as physiological therapies. Both clinic and home must do a speech re-education job. That speech defects are closely interwoven with other handicaps Dr. Hawk proves by citing the fact that in institutions for children with visual and auditory handicaps, speech defects sometimes run 50 per cent *or more.*

Her book begins by emphasizing etiological factors, then gives speech therapies that are co-ordinated with vocal or tone, and body or gesture, language. Carefully graded and detailed exercises are given as well as speech measurement rating sheets, articulation tests, suggestions for the family of the speech defective and an appendix on "Personality Measurement and Vocational Guidance." Dr. Hawk believes with W. S. Sadler that rehabilitation for psychoneurotic and psychotic individuals must involve: (1) the ability to face reality honestly and without fear; (2) cultivation of social outlets; and (3) the ability to recognize and redirect one's neurotic tendencies into safe channels.

In the reviewer's opinion Dr. Hawk's excellent bibliography of books, special articles and speech correction periodicals is alone worth the price of the book.

The Happy Generation. By FERENC KORMENDI. Translated by C. W. Sykes. 635 pages. Cloth. Crown Publishers. New York. 1949. Price $3.50.

Here is a highly overrated, grossly overwritten (635 pages!), and rather boring novel by a Hungarian writer of some reputation. The book, published in 1934, depicts a Hungarian family during the period 1900 to 1933. Psychologically it is confused: No explanations of characters are given, either in the text, or between the lines, nor are the motivations reconstructable even with a vivid imagination. The upshot is that a few unmotivated aggressive women and a few male weaklings are presented, the latter partly with Oedipal trimmings. It is remarkable how lifeless the characters are, and what little psychological insight the author possesses.

Trends in Medical Education. Mahlon Ashford, M. D., editor. XIV and 320 pages. Cloth. New York Academy of Medicine Institute on Medical Education. Commonwealth Fund. New York. 1949. Price $3.00.

In an effort to form a pattern for development in medical education, short articles on the field by leading medical educators are presented and discussed here. The doctor's training is being covered from the time he enters high school until he is a practising physician—and still studying and learning.

As the book is by many hands there are differences in stress and, of course, minor conflicts between the writers, but there is a broad area of agreement. The viewpoint is stressed that doctors must not be simply men of medicine, but citizens, and as such should have a far wider general education, not related to the physical sciences, than is usual—particularly in the high school and pre-medical periods. The study of psychiatry, it is held, should be integrated with general medicine during early years in medical school and carried forward throughout the entire course. In this way, it is pointed out, psychiatry will be realized to be a constant factor in medical life—and not something to be studied for, passed, and forgotten.

The contributors urge that the position in medicine of the general practitioner be strengthened if the best medical service is to be given to all. Any state of affairs in which a good many general practitioners are so merely because they have been prevented by circumstances or lack of funds from taking the necessary training to become specialists is held not to be a healthy one. At the present time it is difficult to obtain further training for general medicine beyond the intern level; with most residencies reserved for specialty training. It is the consensus of the authors that greater encouragement should be given to general practitioners, opportunities for advanced training afforded them, and that they be recognized as an essential part of the medical team.

The Four-Chambered Heart. By ANAIS NIN. 187 pages. Cloth. Duell, Sloane & Pearce. New York. 1950. Price $2.75.

Out of three people and a houseboat on the Seine, Anaïs Nin has constructed a novel. The basic situation is developed quickly and surely: Djuna, the dancer, Rango, her lover, and his hypochondriac wife Zora. The book is narrated in relation to Djuna, her emotions, her fears, her love. Rango, the Guatamalan guitar player who has the dreams, appearance, and vitality to go far—but always becomes lost in his dreams and finds too many diversions to set out for any one goal—is always portrayed from Djuna's viewpoint as is the "sick," complaining Zora. The effect on Djuna's and Rango's relationship of past events and the control exerted by the one carry-over of Rango's past, Zora, is strongly brought out. *The Four-Chambered Heart* holds its interests throughout, which is rather remarkable considering the almost complete lack of tangible action. A real talent on the part of Anaïs Nin, and a real ability to draw characters, unusual characters to be sure, save this from becoming just another bedroom melodrama.

The Delightful Prey and Other Stories. By PAUL BOWLES. 307 pages. Cloth. Random House. New York. 1950. Price $3.00.

There is an atmosphere of the strange and the unusual to these tales. The element of fantasy, while only occasionally present, is always felt to be not far off. The settings, with one exception, are near the primitive; the outward trappings, veneers, and emotions of civilization are stripped off and the human being is left to his own devices. The incongruity of the civilized encroaching upon the savage, and the violence, hidden or obvious, that often ensues, form the central motif. To this reviewer, at least, this collection of tales is more satisfying than Paul Bowles' previously published novel, *The Sheltering Sky*, which had the rather unusual distinction of being a best seller as well as a first class piece of literature.

Analytical Psychology and the English Mind and Other Papers. By H. G. BAYNES. x and 242 pages. Cloth. British Book Centre, Inc. New York. Methuen, London. 1950. Price $4.25.

Several papers presented before various organizations and the first three chapters of an unfinished book by the late Dr. Baynes are collected and published here. As in almost all collections of this type the quality of the material is uneven and at times there is repetition. The title article is well written and interesting, as are some of the others. We are asked to believe from the words of the jacket that "Dr. Bayes made Professor Jung's thought his own, without loss of his own originality." This may be accepted, but only if originality is limited to mean originality strictly within the basic framework; like a good disciple Dr. Baynes never tried to transcend the master.

Modern Abnormal Psychology. A Symposium. W. H. Mikesell, editor. 861 pages. Cloth. Philosophical Library. New York. 1950. Price $10.00.

Many books of this type are published. They are fundamentally textbooks, and persons who do a good deal of book reviewing get tired reading them. Occasionally one appears which is especially well written. *Modern Abnormal Psychology* does not give one any new ideas but it does re-explain basic material of abnormal psychology in a refreshing, as well as instructive, manner. Its title includes the word, "Modern," which probably refers to the authors, most of whom belong to the group of younger psychologists and psychiatrists. These authors have done a finished job of each chapter. Your reviewer enjoyed reading every word.

The chapters of the book discuss normal and abnormal behavior, the history of psychotherapy, causes of mental disease, defense mechanisms, legal and scientific concepts of mental illness, maladjustment, psychological testing, concepts of the unconscious, disorders of perception and imagery, abnormalities of intellect, the psychology of drugs, the neuroses, the psychoses, psychopathic personality, psychosomatic medicine, hypnotism, psychoanalysis and mental hygiene.

The Magic Fallacy. By DAVID WESTHEIMER. 96 pages. Cloth. The Macmillan Company. New York. 1950. Price $2.00.

A form of writing that is very tempting and very difficult to do well is "looking backward": The reader is allowed to know the outcome, usually tragic, and the sequence of events is built up to an inevitable, onrushing, conclusion. *The Magic Fallacy* is built on that pattern, and the author has avoided the usual pitfall: making the story too long and allowing the reader's interest to falter. Set in the environs of Houston, the plot is of the ruining of a boy's life by the break-up of his home, and the entrance into it of a young, sensual, stepmother. Not a great book, nor even a specially distinguished book, this is a very capable handling of a difficult subject, done in a manner that fits it.

An American Dream Girl. By JAMES T. FARRELL. 302 pages. Cloth. Vanguard. New York. 1950. Price $3.00.

Here is a series of short stories by the famous author of the Studs Lonigan trilogy, and the Danny O'Neil tetralogy. Farrel is powerful in description of "social realism." He has the uncanny ability of photographic reproduction; in a few words, a real character is depicted. The trouble starts with psychological motivations; these are neglected, or shifted to the social setting. With this reservation, Farrell's stories are highly readable, especially because, in the present volume, a peculiar and enjoyable type of wit comes to the fore.

Louisville Saturday. By MARGARET LONG. 278 pages. Cloth. Random House. New York. 1950. Price $2.75.

On a Saturday in October 1942 in Louisville, a big military parade brings soldiers to town. This setting is used for scrutiny of 11 girls and women in relation to their "loneliness and frustration, the despair and boredom of women in wartime." There is a peculiar uniformity: All these women are "sick with fascination and disgust"; many feel that they are cheated out of the "love legend"; some complain that "the dominant male collapses into a helpless little boy." A good deal of promiscuity and wondering about inner motives come to the fore; nowhere (either in the text, or between the lines) does the author give any indication as to why her *dramatis personae* act as they do. The matter of sexual attraction is highly overrated and simplified. Were the book mere reporting, there would be no objection to it, but as a psychological novel it is too thin. This is a pity because Miss Long shows real compassion; psychologically, her work is lacking.

The Little Blue Light. By EDMUND WILSON. 163 pages. Cloth. Farrar, Straus and Company. New York. 1950. Price $2.75.

This play is intended as a study and satire of personality types, and a plea for justice and humanity in a world filled with hate—a world set some years in the future when conflicting pressure groups have destroyed liberalism and are fast destroying freedom. An attempt is made, not particularly successfully, to bring out the influence of past traumatic experiences on the characters. The success of this play lies not in its high intentions, but in the fact that Edmund Wilson has written an absorbing story with an atmosphere of fantasy and uncertainty that holds the reader's interest throughout.

The Dark Voyage and the Golden Mean. By ALBERT COOK. 188 pages. Cloth. Harvard University Press. Cambridge. 1949. Price $3.50.

The Sacred River: An Approach to James Joyce. By L. A. G. STRONG. 161 pages. Cloth. Pellegrini and Cudahy. New York. 1951. Price $2.75.

The Dark Voyage and the Golden Mean is a study of the philosophy of comedy. Albert Cook holds that there are two different techniques for attacking human experience, the probable and the wonderful, and that comedy is the expression of the probable, and often, an expression of the punishment society inflicts upon seekers after the wonderful. Tragedy has a normal setting, from which the spiritual concept of the wonderful evolves, while comedy on the other hand, spiritually holds fast to the norm, while upon this norm it superimposes the unexpected. The Freudian the-

ory, that the structure underlying both the dream and comedy are similar, but that "The dream serves preponderantly to guard against pain, while wit serves to acquire pleasure" is accepted, but is held to be only a part of far broader implications. After making the points that are the main purpose of the book, Cook goes on to studies of individual authors and books in the light of his conclusions; such as the plays of Aristophanes and Molière, the works of Homer and Fielding, and James Joyce's *Finnegans Wake*.

Cook's analysis of James Joyce and *Finnegans Wake* take a quite different point of attack from that of Strong in *The Sacred River*. Cook holds that the basis of *Finnegans Wake* is within the framework of the probable, utilizing a limited, categorized, number of personality types—and is therefore definitely not romantic. Strong holds that romanticism is a turning inward to the subconscious and that *Finnegans Wake* is its logical fulfillment. This reviewer believes the book to be essentially romantic in character. Joyce was influenced by many people: Shakespeare, Blake, Swift; the theories of Vaco, Freud, and especially Jung—it is the influence of William Blake and his mysticism that has been shown in *The Sacred River* and passed over by Cook.

Of the two writers, Strong is the better. He has perhaps not the sheer power of Cook, but he has learned to put his points across fairly simply and explicitly without hitting one over the head with his learning at every step. Both books are worth while and show good reasoning power.

Client-Centered Therapy. By CARL R. ROGERS, Ph.D. With chapters contributed by Elaine Dorfman, M. A., Thomas Gordon, Ph.D., and Nicholas Hobbs, Ph.D. 560 pages. Cloth. Houghton-Mifflin. Boston, New York. 1951. Price $4.00.

This stimulating book is a welcome supplement to Rogers' earlier work, *Counseling and Psychotherapy*. It is a reflection of the rapid advances that have been made in the theory and technique of client-centered therapy in recent years. Its success stems from the author's broad experience as therapist and teacher, and from his open-minded, scientific, and creative approach to therapy. Rogers and his collaborators show the possibilities of the non-directive method in play therapy, group therapy, teaching, and administration. Significant research is reviewed and many verbatim transcriptions from client-centered situations are provided to illustrate the principles expounded. The training of counselors and therapists is discussed in detail and in the closing chapter a phenomenological theory of personality is offered.

Rogers' approach to human relations has deep implications for a democracy. One cannot afford to miss reading this book.

Trial of Dr. Lamson. (The Blenheim School Murder) (Second edition.) Hargrave L. Adam, editor. 216 pages. Cloth. William Hodge and Co., Ltd. London. (British Book Centre, New York.) 1951. Price $3.50.

Trial of Mary Queen of Scots. (Second edition.) A. Francis Steuart, editor. 206 pages. Cloth. William Hodge and Co., Ltd. London. (British Book Centre, New York.) 1951. Price $3.50.

Trial of Ronald True. (Second edition.) Donald Carswell, editor. 295 pages. Cloth. William Hodge and Co., Ltd. London. (British Book Centre, New York.) 1951. Price $3.50.

Trials of Patrick Carraher. George Blake, editor. 278 pages. Cloth. William Hodge and Co., Ltd. London. (British Book Centre, New York.) 1951. Price $3.50.

The "Double Tenth" Trial. War Crimes Trials. Vol. VIII. Colin Sleeman and S. C. Wilkin, editors. 324 pages including index. William Hodge and Co., Ltd. London. (British Book Centre, New York.) 1951. Price $4.25.

The first three of these volumes are new editions of works previously published in the Notable British Trials series. *Trials of Patrick Carraher* and *The "Double Tenth"* are new.

Trial of Dr. Lamson is of interest to students of medical jurisprudence in that it involves the rather unusual matter of poisoning by aconite.

Trial of Mary Queen of Scots is an apparently objective presentation of well-known historical material.

Trial of Ronald True is one of the most notable of British actions involving the defense of insanity. True was found guilty and sentenced to death in spite of the medical testimony which indicated abnormality from his childhood. His sentence, however, was commuted by the Home Secretary, who apparently had no choice in the matter, and True died in Broadmoor nearly 30 years after his crime. Much of the conduct of his trial turns on the interpretation of the famous M'Naughton rules. These are given verbatim in an appendix to this volume, as is a special report of a committee on insanity and crime named following the True trial. Since the M'Naughton rules are of almost as much importance in American as in British jurisprudence, this whole discussion is illuminating and useful to the American psychiatrist faced with the problem of insanity defense.

The new volume of the Notable Trial series, *Trials of Patrick Carraher,* is a social as well as a legal document. Carraher was tried twice for mur-

ders in the slums of Glasgow, convicted of the second in 1946, and hanged. *The "Double Tenth" Trial, a War Crimes Trial,* is the record of Japanese mis-treatment of civilians captured at Singapore in World War II. Aside from its value to persons interested in the legal constitution and procedure of the war crimes trials, this volume is of principal interest as a documentary record of sadism.

Ye Shall Be Comforted. By WILLIAM F. ROGERS. 89 pages. Cloth. Westminster Press. Philadelphia. 1950. Price $1.50.

Not all who offer consolation to grieving friends are equipped to deal with sorrow effectively, yet medical and psychiatric research recognizes excessive grief as a destructive force from which the sufferer must be liberated.

Analysis of contradictory emotions involved in grief, with acceptance of one's own guilt feelings toward the dead, needs the intelligent handling of a skilled counselor with whom to talk out one's emotional tensions. A clergyman, Dr. Rogers indicates, is the logical person to be this guide in the dark hours when cynicism, remorse and self-condemnation threaten the bereaved's peace of mind.

Principles of mental hygiene are presented clearly, sympathetically and intelligently and the book closes with a series of quotations, scriptural and classical, which have comforted mankind throughout the ages.

Nightrunners of Bengal. By JOHN MASTERS. ix and 339 pages. Cloth. The Viking Press. New York. 1951. Price $3.00.

There is evidence that an attempt was made to transform this book from a historical novel to a study of mental breakdown brought on by trauma, but happily the attempt was soon abandoned. As a historical novel a mild success must be scored—the fan will find a sufficiency of violence and intrigue, with a good sprinkling of sex. The psychological aspect is unconvincing, but there is not a sufficient emphasis placed upon it to color the whole novel.

The Edge of the Night. By JOHN PREBBLE. 325 pages. Cloth. William Sloane Associates. New York. 1948. Price $3.50.

The themes of the disgust and futility of war, and the hopelessness of a conquered people have been covered well, and this novel says little that has not been said elsewhere with greater effectiveness. The characterizations ring true but are stereotyped. This is not to imply that the book cannot be found enjoyable, but, on the whole, it must be labeled undistinguished.

The Folklore of Sex. By ALBERT ELLIS. 313 pages including index. Cloth. Charles Boni. New York. 1951. Price $5.00.

Dr. Ellis' book is a survey of the manifest attitudes toward sex (as distinguished from actual behavior) of the American people, as revealed in books, magazines, plays, advertising and general entertainment. Dr. Ellis, as he himself noted in a *Saturday Review of Literature* article which, to some extent summarized the conclusions of his book, found ambivalence in reactions to virtually all subjects from fornication to sex education. This is a result which will surprise no psychiatrist and could have been no great surprise to Dr. Ellis himself who has a psychoanalytic background. There is little or no discussion of psychodynamics.

A statistical chapter is appended to the survey material, which is largely reported in paraphrase or direct quotation. This reviewer is in no position to assess the statistical validity, but he thinks questions will be raised as to the representative quality of the sample studied and as to the subjective judgments involved in classifying the material. Dr. Ellis concludes that our present inconsistency in attitude must either go forward toward further liberalism or return to a more conservative pattern. He thinks present ambivalence cannot be tolerated indefinitely.

This conclusion also is of a nature which will not surprise anybody. The style of writing in this book is non-scientific, flippant and fairly bristling with "wisecracks." This reviewer does not think Dr. Ellis has met his own announced objective of producing a serious or significant study of American attitudes toward sex, love and marriage. He does, however, think that many serious scientists, as well as other readers, for whom much of it is certainly adapted, will find the compilation amusing.

The New York Academy of Medicine. Its First Hundred Years. By PHILIP VAN INGEN, M. D. XII and 571 pages. Cloth. Columbia University Press. New York. 1949. Price $10.00.

The New York Academy of Medicine, professional organization of the physicians of New York City, observed its centenary in 1947, and in celebration of the event a history of the organization was prepared by Dr. Philip Van Ingen and made number eight in the publications of the academy on the history of medicine. In gathering the material the publications of the academy were studied; and references to, and comments about, the academy in periodicals and newspapers have been unearthed. Dr. Van Ingen takes a neutral course in matters of controversy and personality, holding the role of simple narrator of, rather than commentator on, events. The history is written chronologically rather than topically, and this, while facilitating the use of the book as a reference work, precludes the possibility of it being found really enjoyable reading by others than students of medical history and members of the academy.

Stephen Crane. By JOHN BERRYMAN. xv and 347 pages. Cloth. William Sloane Associates. New York. 1950. Price $4.00.

There has been nothing of importance done on Stephen Crane since the '20's when Thomas Beer wrote his standard work, and this new book is badly needed. Until the last small section it is a literary study, then suddenly the reader is transported to a different world. Instead of a literary biography he is reading a Freudian analysis which is both profound and abstruse. While the analysis is well thought out, as far as it goes, it is out of character with the rest of the book and seems to have been put there as a tag-end rather than as an integrated part of the whole. Berryman goes into Stephen Crane's deep mother fixation, sexual symbolism, and identification with people and even animals, particularly horses, in his stories.

Bitter Wine. By ALBERT SCHONBAR. 136 pages. Cloth. Exposition Press. New York. 1950. Price $2.50.

Frederick Behren, a young immigrant from Libau, comes to America with all the high hopes, ideals and dreams of success that characterize his counterparts in fiction. His steady climb brings in its wake a ruthless wife, talented and over-sensitive children and finally the unpredictable collapse of the fortune Behrens has struggled so hard to amass.

The reader plods forward through a morass of dreary frustrations and defeats that culminate in the son's suicide because he embodies his father's pacificist tendencies in a world that cannot understand them. When the mother becomes responsible for her son's downfall by writing the newspaper editorial that brands him "traitor" the reader's credulity is stretched far beyond the breaking point.

The Secret Game. By FRANCOIS BOYER. Translated from the French by Michael Legat. 187 pages. Cloth. Harcourt, Brace. New York. 1950. Price $2.50.

The author uses the march of French refugees, fleeing from advancing Nazis, during the summer of 1940, to single out an episode of a nine-year-old girl whose parents were killed by Nazi fliers. The novel pretends to be an excursion into "the terrifying, delightful magic of a child's world." It is, however, a truly silly caricature of what a scenario writer for French films (this novel is the first "literary" effort of Mr. Boyer) imagines to be the "child's world." For one banal detail: The author has, in his narrative, the tendency of word-reiteration; his heroine does likewise. Much of the "humor" in the story is derived from blasphemous situations. The really interesting problem in this production is: What was the idea of an editor and publisher in promoting this summation of unpsychological trivia?

De Profundis. By OSCAR WILDE. Edited with an introduction by Vyvyan Holland. 148 pages. Cloth. Philosophical Library. New York. 1950. Price $3.00.

Oscar Wilde served two years in prison for sex perversion, and *De Profundis* is the letter, written in prison, to his almost constant companion of the previous three years, Lord Alfred Douglas. It is a strong, while at the same time not especially bitter, rebuke and appraisal of Douglas' character. Wilde for years had loudly and insistently championed "aestheticism" and "Art for Art's Sake," and many of his writings, such as *The Picture of Dorian Gray,* had frankly homosexual overtones. Wilde points out in *De Profundis,* however, that not these facts, or even his sexual activities, were the direct cause of his being sent to prison. The direct cause was a suit for libel that he brought against Alfred Douglas' father and which backfired. This action was brought only because of Douglas' intense hatred of his father, and his desire, no matter what the cost, to hurt him. Wilde paints Lord Alfred Douglas as a spoiled child, thoughtless always, his extravagances finally leading Wilde to bankruptcy.

Wilde claims that the specific charges brought against him in court were false, but admits quite readily the general charge. He takes the not too unexpected view in homosexuals that the soul and emotions are everything —the physical nothing. Throughout, Wilde paints himself as a sensitive, sensual, person, and there is a crying note of "How could this happen to me?" recurrent in the work.

De Profundis was originally published, in incomplete form, in 1905, the publication of the whole being delayed until after the death of Lord Alfred Douglas in 1945.

Logan Clendening Lectures on the History and Philosophy of Medicine—First Series. By JOHN FARQUHAR FULTON. 52 pages. Cloth. University of Kansas Press. Lawrence, Kan. 1950. Price $1.00.

Two lectures, the first on Andreas Vesalius, the great innovator in the study of anatomy, and the second on medicine in the XVIII Century, initiate a series to be published in honor of the late Dr. Logan Clendening. Mr. Fulton has given a concise readable account, stressing the importance of an inquiring mind and true objective reasoning in scientific pursuits. There is little or no philosophy or psychology in the lectures, but there is a good historical evaluation of the services to later generations of the early experimenters. The first lecture, on Vesalius, better accomplishes its purpose than the second, which, even though narrowed into three classifications, physiology, pathology, and internal medicine, still compresses too much into too little space and leaves a feeling of incompleteness.

It will be interesting to see the following lectures in this series, as they could well fill a need for easily comprehensible studies in medical history.

The Front Is Everywhere. By WILLIAM R. KINTNER. 253 pages. Cloth. University of Oklahoma Press. Norman, Okla. 1950. Price $3.75.

The author, lieutenant colonel of the United States Army, has written a well-documented, scholarly, and useful book devoted to the proof that Communism and its "parties" are essentially a military organization. He rightfully insists that the military aspect of the Communist movement "has been tragically ignored by its potential victims" (p. 15). His conclusion reads:

"Whatever action is taken, the American people should not approach the problem of Communism in a spirit of defeatism. It is dangerous to assume that a democratic system cannot develop adequate and safe countermeasures against an illegal conspiracy to overthrow it by military force. A democracy can uphold its principles without courting suicide. For less than two hundred years, a few generations of the American people have secured the blessings of liberty to themselves and their posterity. The liberty they have secured is not a common thing. In the annals of human history tyranny is common, but liberty has been all too rare. Every people possessing liberty has lost it, after a span of time, for one reason or another—most often because the defenders of liberty were few and were unable to withstand the assaults of the foe without and the foe within. Each generation of free people has its unique duty to perform in the preservation of liberty. May ours be equal to its task." (Pp. 252-3.)

Jailbait! The Story of Juvenile Delinquency. By WILLIAM BERNARD. 216 pages. Cloth. Greenberg. New York. 1949. Price $2.50.

This is a popular work, by an experienced writer, on juvenile delinquency. He has gone to federal, state and other agencies for his material; most of it can be recognized as familiar by workers in the sociological and psychiatric field; and the book can be accepted generally as factual. It is, however, and doubtless with the best intentions, presented with a sensationalism which ranges from the title *Jailbait!* through such chapter headings as "Statistics on Sin," "The Juvenile Prostitute," "Hayloft and High School," to "Whose Blame?" and "Whose Shame?" The author is critical of various religious, educational and psychiatric efforts to cope with the problem.

This reviewer thinks Bernard's work would have been of considerably more social value if the picturesque qualities had been deliberately minimized and the book as a whole adapted for formal study as well as for general reading. As it stands, it is likely to attract an undue proportion of readers in search of pornography and not a large enough proportion who could be interested generally in combating the juvenile delinquency problem.

Freud: Dictionary of Psychoanalysis. By NANDOR FODOR and FRANK GAYNOR. 208 pages. Cloth. Philosophical Library. New York. 1950. Price $3.75.

This is a scholarly and intelligent attempt to compile a dictionary of psychoanalytic words and phrases from the writing of Freud himself. This reviewer thinks it is a promising start toward the eventual compilation of an authoritative reference work. It falls short, however, in completeness of topics defined and in completeness of definition. From the student's point of view a serious fault is that the definitions, although referring to specific writings, are not dated. There is no easy way for the person who is not already thoroughly familiar with psychoanalysis to determine whether a given quotation is from Freud's later or earlier work. The psychoanalyst who is thoroughly grounded in the development of Freud's thought can thus make more use of this small dictionary than the student, who needs it more. The present edition, however, will satisfy many a requirement for exact quotation and will serve to correct some of the extraordinary misapprehensions which most of the uninitiated have concerning what Freud said and what he meant by it.

These criticisms may very well be answered in future editions. The reviewer wonders, however, if a concordance to standard available editions of Freud—or the long-awaited index—would not be of considerably more general use than a dictionary.

Social Class in America. A Manual of Procedure for the Measurement of Social Status. By W. LLOYD WARNER, MARCHIA MEEKER and KENNETH EELLS. 274 pages. Cloth. Science Research Associates. Chicago. 1949. Price $4.25.

"This book," say the authors, "presents basic material about social class in America, tells how to identify the several levels, and describes the movement from lower levels to higher ones. The fundamental functions are to tell the reader (1) how to identify any class level, and (2) how to find the class level of any individual. It makes it possible to learn by reading and study, rather than through half-knowledge and confused emotions of experience, what social class is and how to study and measure it."

The first chapter explains what social class is and gives an idea of how it operates in different sections of the country The second gives an overall view of the two methods used by the authors to measure social class status. The following chapters give details of the methods employed in use of these techniques and provide for instruction and practice. The final chapter provides a commentary of some books and articles which give background material about social class, and demonstrate the use of the authors' two techniques.

This book may be of value to students of the problems of understanding and measuring social classes.

The Bases of Human Behavior. A Biologic Approach to Psychiatry. By LEON J. SAUL, M. D. 150 pages. Cloth. Lippincott. Philadelphia, London, Montreal. 1951. Price $4.00.

An understanding of human nature can best be approached with man pictured as a "biologically homogeneous organism," according to Dr. Saul. In this elementary text on dynamic psychiatry he has realized his comprehensive aim—to impress the reader with the reality of emotional forces, how they originate in the organism's biological make-up, and the manner in which they are related to physiologic function. He clarifies psychosomatic relationships in his exposition on temporary physiologic change and on permanent tissue damage, which can be produced by emotional forces. Disorders in the perceptive, integrative, and executive functions of the brain, caused by emotional forces, are discussed. Behavior disorders, such as kleptomania, alcoholism, "fate neurosis," and criminality are sometimes the chief features of an emotional disturbance.

The author's artistic and philosophic way of expressing his ideas, as well as the informative content, makes this book well worth reading.

Nietzsche. By WALTER A. KAUFMANN. XI and 409 pages. Cloth. Princeton University Press. Princeton. 1950. Price $6.00.

A great many people claim to have a good comprehension of Nietzsche and can talk glibly about "the will to power" and "the Superman." It is Professor Kaufmann's contention that the concept of Nietzsche which has grown up in the minds of the people is an erroneous one, constructed first by his sister, Frau Förster-Nietzsche, and later by the Nazis. Anti-Semitism and extreme nationalism, both principles which Nietzsche abhored, were read into his works, largely by means of the publishing of his scattered notes and the labeling of them as his "last and greatest work" by his sister. Those holding these views chose to ignore the significance of his final and irrevocable break with the ideologies of Wagner, and pushed aside Nietzsche's own unmistakable words on the subject by the simple expedient of claiming that he didn't mean what he said.

Professor Kaufmann's treatment of Nietzsche's psychosis is less satisfactory than this analysis of his theories. Nietzsche's final complete breakdown due to, almost certainly, general paresis, is simple enough, but in saying that Nietzsche was able to ward off the final breakdown as long as he had anything left to say, and that it was only when he had exhausted his powers that the psychosis overcame him, Professor Kaufmann is going out on a limb. The influence of Nietzsche's psychosis on his writings is difficult to judge, and Professor Kaufmann cannot be criticized for holding that it had little or no effect on the basic thought, but that it did make itself apparent in some of the flights of ideas in his later works.

A History of Medicine. Volume 1. By HENRY SIGERIST, M. D. xxi and 564 pages. Cloth. Oxford University Press. New York. 1951. Price $8.50.

Planned for eight volumes, this history of medicine, if it continues at the level here reached, should remain the standard work for years to come. Dr. Sigerist has used a cautious approach to early medicine, indicating where conflicting theories are held. He is not, however, afraid to challenge extravagant ideas and conclusions if he feels they are unjustified. No distinction is made between the magic and science of medicine, a fusion of which is, after all, the basis of psychiatry.

This first volume covers primitive medicine and the medicine of Egypt and Mesopotamia. The section on Mesopotamia is the least satisfying, as a great deal more research must be done on material that is already available. The reader finds himself wishing that the writing could have been delayed until many unanswered questions were answered.

Confessions of a Poet. By PAUL VERLAINE. 192 pages. Cloth. Philosophical Library. New York. 1950. Price $3.00.

The confessions of a major poet, written at the end of his hectic, tortured, life might be supposed to add much insight into his motivations and writings. This, however, is not the case with Verlaine. Despite a great deal of frankness and many facts presented, there has been little differentiation between the various degrees of influence exerted on his character; and the chronicle ends before the entrance into the household of Rimbaud. Many of the expressions of guilt on the part of Verlaine are easily understood when it is remembered that he was, at the time of writing, a rather hopeless alcoholic at the end of his career. Nothing is said of the alleged homosexuality of his relationship with Rimbaud except a vague statement that many things said about him were not true at the time said. All in all, it is as a piece of literature and a source of stray bits of information that this book must be accepted, not as a man revealing to the world the workings of his mind.

Principles and Techniques in Social Casework. Cora Kasius, editor. 433 pages. Cloth. Family Service Association of America. New York. 1950. Price $4.50.

Thirty-two articles dealings with the theory and practice of social work have been reprinted from *Social Casework*, where they appeared between 1940 and 1950. The selection is good, although, as is inevitable with this type of compilation, there is little feeling of unity in the book. The necessity for the social worker to have a thorough grounding in psychoanalytic theory has received commendable emphasis.

Sex Questions and Answers. By FRED BROWN and RUDOLF T. KEMPTON. 264 pages with index. Cloth. Whittlesey House. New York. 1950. Price $2.95.

"The content of this book is based upon 1,126 written questions which were submitted anonymously to the authors by men and women in the United States Army." As such, the book is in keeping with the modern trend toward taking sex "out of the cellar and airing it on the line." In doing this, however, the authors have successfully integrated factual knowledge with practical application.

Chapter headings vary from "The Biology of Sex" to "Psychological Problems of the Orgasm," resulting in a work that covers a tremendous range. The only criticism is that it is an oversimplification, with resulting superficial and possibly inadequate analysis of certain aspects of the subject matter. However, the book is directed at the layman, and factual information is handled in an objective and accurate manner.

Second Sight in Daily Life. By W. H. W. SABINE. 208 pages. Cloth. Coward-McCann. New York. 1949. Price $3.00.

The study of the nature and existence of extrasensory perception has usually been clouded with feelings of strong personal prejudice or fanaticism. If only for the calmness with which the subject is approached, this book deserves credit. Precognition is held to be a fact, but is not held to be prophetic in the sense of often foretelling events of great import. A belief in the possibility that all dreams are precognitive is held by the author—the unconscious at times using symbolism to portray the coming incident. This is not an important or monumental book; the material is largely from the author's personal experience and is not experimental. The book makes interesting reading but is not likely to change greatly any previously-held opinions.

Burning Bright. By JOHN STEINBECK. 159 pages. Cloth. Viking. New York. 1950. Price $2.50.

Written in an experimental style reminiscent at times of Eugene O'Neill, *Burning Bright* tells of the developments leading from an older man's infertility and his younger wife's great love for him. The form is that of a play-novelette: a novelette from which the dialogue can be lifted to form a play. The action is continuous, with the same characters, in the same roles, being put in different settings in the different acts in an effort to create an atmosphere of universality. Thus, Joe Saul in the first act is a circus performer, in the second a farmer, and in the third a ship captain. There is little effort at naturalism, the characters, whether circus performers or farmers, being timeless and not in accord with their settings.

Sir Thomas Browne. By WILLIAM P. DUNN. VIII and 182 pages. Cloth. University of Minnesota Press. Minneapolis. 1950. Price $3.00.

The sixteenth century was a time of religious intolerance and a transition period from the wonders of the Renaissance to the new science. Sir Thomas Browne illustrates how a reasoning man may try to develop and yet be caught up in the beliefs and ideas of his times. In *Religio Medici* little of the narrow sectarianism characteristic of the century is to be found. Labeled heretical by many when published, it refuses to limit its ideas to the dogmas of any one interpretation of the Bible, and at times strikes a distinctly mystical note. But Browne cannot escape the prevailing scientific ideas, and he finds himself incapable of following clear lines of reasoning to scientific conclusions too much at variance with the accepted standards.

Professor Dunn follows the philosophical and religious ideas of Browne through his various works, and not so much interprets as explains them. It is a scholarly work, well executed, but too specialized and detailed for wide popularity.

As a Man Grows Older. By ITALO SVEVO. xxii and 245 pages. Cloth. New Directions. New York. 1949. Price $3.00.

The reputation of Italo Svevo has gone through two stages; first he met complete indifference and then fervent adulation. The reprint of this novel shows that he deserves neither. An older man becomes infatuated with a young woman, lacking in both character and intelligence. He is able intellectually to realize what is happening, but being unable to reconcile his emotions and his intellect, he lives in two worlds. Throughout, the focus of attention is on the weakness of human personality and not on the strength.

The Psychology of Sartre. By PETER J. R. DEMPSEY, O. F. M. Cap. 173 pages. Cloth. Newman Press. Westminster, Md. 1950. Price $3.00.

The existentialism of Sartre, with its components of subjectivity and atheism, have been criticized in the light of Thomistic philosophy. The author has rendered a criticism that traces the development of Sartre's thought back to that of Descartes, and the Sartrean view of emotion is held to be: "An extremely personal account of one man's outlook on the world and his reaction to it, its value is that of a case history. It is the autobiography of a neurotic." Not a book for the casual reader, this is rather heavy plodding at times, as it is often difficult to abstract the central thesis from a maze of ideas.

Alfred Tennyson. By His Grandson, CHARLES TENNYSON. XV and 579 pages. Cloth. Macmillan. New York. 1949. Price $7.50.

Within a rather limited field this book fulfills its purpose as a biography of Alfred Tennyson. Charles Tennyson had access to certain facts and letters not available to others, and has incorporated his new information into this book. The result has been a fuller coverage of the poet's unhappy early life than has before been available. There is little attempt to analyze Tennyson's writings, and the facts presented about the mental disorders of Alfred Tennyson's father, brothers, and the poet himself are totally inadequate. There is an apparent attempt to pass over lightly what, to the author, must be an unpleasant aspect of the family history.

On Being Human. By ASHLEY MONTAGU. 125 pages. Cloth. Schuman. New York. 1950. Price $1.95.

"Survival of the fittest," and competition have been generally assumed to be the basis of the natural law of life. Rather than this, Ashley Montagu believes co-operation to be the norm among living animals. With a few exceptions, animals seek their own kind; and, by this theory, natural selection would depend upon the ability of a new form to co-operate in the social structure. This little book has been designed for popular, rather than scientific reading, and a larger and more technical work has been promised for the future.

The Integration of Psychiatry and Medicine. By WILLIAM B. TERHUNE, M. D. xii and 177 pages. Boards. Grune & Stratton. New York. 1951. Price $2.75.

The basic idea of this book is to be commended, and the material is presented in an orthodox, interesting fashion, but it is far too sketchy in character, as its avowed purpose is to be "an orientation for physicians." Because of its superficial treatment it is of slight value as a medical reference work, and the information given is not such as to make it required reading for many physicians. It should, however, be exceedingly useful for nurses, social workers and members of other disciplines allied to medicine.

The Structure of Human Abilities. By PHILIP VERNON. x and 160 pages. Cloth. John Wiley & Sons. New York. 1950. Price $2.75.

In opposition to some of the late American research, the author, using the factor analysis method, has upheld the principle of a general "g" factor in intelligence, and has proposed a hierarchy of other factors which are at least partially inseparable from the "g" factor. Original research is not the major portion of this work, the book being more an explanation and re-evaluation of previously published material. The book is highly technical in approach and will be found rewarding by a limited group.

Voluntary Parenthood. By JOHN ROCK, M. D., and DAVID LOTH. 307 pages. Cloth. Random House. New York. 1949. Price $3.00.

In a popularly-written, easily-comprehensible book the case for voluntary parenthood is set forth. The authors are for full public knowledge of the use of artificial means of contraception. Many popular misconceptions of sexual practices are explained and the causes and treatment of infertility are gone into in some detail. A medical approach is urged to the social implications of marriage and child bearing. Medical care for the infertile is urged—urged in preference to subsidizing children, as one of the main reasons for child subsidization is to prevent economic inequalities between the childless and those with children. Statements are quoted from all leading religious organizations "to allow the reader to make up his own mind about the ethics involved."

Organization and Pathology of Thought. Selected Sources. Translation and commentary by David Rapaport. xviii and 786 pages. Cloth. Columbia University Press. New York. 1951. Price $10.00.

Foreign writings not hitherto available in English have contributed much to our conceptions of the processes of thought. In compiling this source book, David Rapaport has used as his main criterion for selection this previous unavailability. Only where this standard would involve the omission of material absolutely essential to general comprehension has a piece been included that can be easily found elsewhere. Very extensive annotating has been done throughout, it not being at all unusual to find more footnotes than text material; and in his commentaries Rapaport has adhered to psychoanalytic principles. The ideas presented have been summarized and evaluated, but no general theory has been set forth.

The Ethical Basis of Medical Practice. By WILLIAM L. SPERRY. 185 pages. Cloth. Paul B. Hoeber, Inc. New York. 1950. Price $2.50.

The ethics of medicine are a static and rigid thing, far more so than those of any other profession. They are now being assailed from many sides by those who propose to alter them in favor of the group rather than of individuals. The author of this book is a minister, dean of the Harvard Divinity School, and he takes a strong stand for continuance of the individualistic approach; the needs of the individual, once the case is undertaken, are supreme, and any obligation to society must be secondary. For example, the author has no great disagreement with self-willed, carefully-regulated euthanasia *as such*, but does not agree that law should permit it, because of the likelihood of careless administration and because such laws would be a stepping stone toward a totalitarian concept of medicine.

The Nursery School. By KATHERINE H. READ. 264 pages. Cloth. Saunders. Philadelphia and London. 1950. Price $3.50.

The implications of this book go beyond the nursery school. Parents, as well as students, for whom the book was written, should feel better acquainted with the young child after reading it. Its excellent organization and the extensive bibliographies at the end of each chapter should make it valuable also as a reference book. The author's viewpoint is perhaps best reflected in her words: "We have taken a big step when we have learned to *observe* children, to recognize the *uniqueness* of each individual, to search for *meaning* back of an act, to *accept the child as he is* and have confidence in his growth impulses."

Introductory remarks emphasize that students must be aware of the part their own insecurities or emotional conflicts may play in their relations with children. The nursery school set-up and its children are described. The second part of the book deals with guiding children in speech and action and helping them to adjust to new and routine situations. Part III, "Understanding Feelings in Areas Where Feelings Are Strong," is particularly well done. Among other things, the author stresses the importance of feelings of security and adequacy, and presents a sound program for handling hostility and aggression. Dramatic play, creative expression, handling parents, and accepting responsibility are discussed in the last part of the book.

Antisemitism in Modern France. Vol. I. By ROBERT F. BYRNES. x and 348 pages. Cloth. Rutgers University Press. New Brunswick, N. J. 1950. Price $5.00.

In a study where the main requirement is a deep scholasticism, Professor Byrnes has done admirably to maintain the level of readability that he has. Modern French anti-Semitism before the Dreyfus affair, its origins, scope, and influence, have been traced. The anti-rationalistic philosophy prevalent, the influence of current European thought, and the transference of emotions from anti-Masonry to anti-Semitism; all these culminated in the publication in 1886 of *La France Juive* by Edouard Drumont and have received exhaustive attention.

An Introduction to Modern Psychology. By O. L. ZANGWILL. xi and 227 pages. Cloth. Philosophical Library. New York. 1951. Price $3.75.

Designed to be read by the inquiring layman, this pocket-sized book fulfills its purpose admirably. A tendency on the part of the author to take great care not to offend anyone—to the extent of almost never expressing a decisive opinion—is somewhat excusable because of the limitations imposed by the purposes of the "Home Study Books," of which this is a member. The treatment of psychoanalysis is orthodox and sympathetic, though again, very cautious.

Your Life Is in Your Glands. By HERMAN H. RUBIN, M. D. 192 pages. Cloth. Stratford House, Inc. New York. 1948. Price $2.75.

This book presents in clear readable English the main facts about the endocrine glands and their bearing on our lives. The author devotes a chapter to each gland, discussing its physiology and disorders. He then deals with the interrelationship of glands and vitamins, glands and obesity, the effect of glands on aging, and on personality. The last part of the book is concerned with the problems of rejuvenation and prolongation of life, and of diagnosis and treatment of glandular disorders.

There is much that stimulates the imagination in this book, such as the hypothesis that the pineal may have once been the organ of sight. Some hypotheses, however, are presented as fact. In his enthusiasm, the author overlooks the complexity of personality. He states, for example, that the "dominance of the adrenal manifests itself in mechanical ability and efficiency." This book will contribute to the critical reader's understanding of the glands but will mislead the psychologically uninformed.

Diagnosis and Process in Family Counseling. M. Robert Gomberg and Frances T. Levinson, editors. 243 pages. Cloth. Family Service Association of America. New York. 1951. Price $3.75.

The sub-title of this book is "Evolving Concepts Through Practice," and this sets the keynote for all the articles included. By having all articles done by members of one agency, in this case the Jewish Family Service of New York, an over-all picture is obtained. The importance of collaboration and consultation between the psychiatrist and the case worker has received full recognition. The many illustrations from case histories help to prevent this book from straying from its announced purposes.

Paracelsus. By HENRY M. PACHTER. xii and 360 pages. Cloth. Schuman. New York. 1951. Price $4.00.

Mystic, magician, alchemist, physician, Paracelsus, one of the chief figures identified with the Faust legend, is not a man to inspire light emotions. The author is definitely an admirer of Paracelsus, but he does not fall into the common trap of desperately trying to attribute orthodoxy and respectability to a man who hated both. Consistently seeming to be trying to prove the world against him, Paracelsus' actions succeeded in alienating friend after friend, patron after patron. If Paracelsus is to be admired, he must be admired for the trends he developed and not for single items and ideas. Readable and logical, this biography avoids ingenious and devious explanations, and its conclusions are consistent with the character of the man.

Southern Legacy. By HODDING CARTER. V+186 pages. Cloth. Louisiana State University Press. Baton Rouge. 1950. Price $3.00.

Hodding Carter likes the South. It is a liking which, while emotional, is not blinded by its emotion. The South he describes, lives in, and analyzes, is essentially a feudal land, not alone in economy, but in attitudes. It is clannish; subject to violent conflicts within the clan, but bitterly resenting any pressure from without. It is a land where a newspaper editor may have to defend his ideas with pistol and shotgun, but will hear the same people who damn him among themselves strongly defend him when talking to an "Outsider."

In talking of this land Hodding Carter combines three qualities that do not often go together; he is a liberal, a southerner, and a realist. As a liberal newspaper editor he has spoken out time and again for civil reforms—well enough to earn a Pulitzer Prize—and, in this book, he is quick to concede and decry many bad aspects of southern life and culture; as a southerner he feels an almost fierce pride in the heritage and traditions of the South; as a realist he accepts the bad features, realizes they must some day be changed, and also realizes that the changes will never be sudden or drastic.

Mr. Carter believes that the present-day South, its strength and its weaknesses, are directly a result of the factors of development, and of the disruption of the Civil War. He explains every personality type from "poor white" to "bourbon" in terms of the War and post-war reconstruction. On reading the book one is struck by the logic of the analyses; it is possible to disagree with Hodding Carter's reasoning and conclusions, but it is difficult not to respect and admire them. In any event, the book is enjoyable to read, which, considering the potentialities for dullness in the subject, is an accomplishment.

In Defense of Mothers. By LEO KANNER, M. D. 167 pages. Cloth. C. C. Thomas. Springfield, Ill. 1950. Price $3.00.

This is Kanner's first excursion into popular writing on child psychiatry. It is his attempt to help modern bewildered mothers face child-upbringing in a realistic common sense way. According to the author, parents, who "cannot win" anyway, are foolish to accept everything they hear in regard to preparing their child for the future. He portrays the usual parent-child clashes objectively and sympathetically from both the child's and parent's viewpoint. There are good illustrative cases.

Witty language and descriptions make the book enjoyable reading. He is liberal with satire on modern theories and psychoanalysis. His invective against the latter, although good-natured, seems overdone. In addition he refers inaccurately to the ego as "plain unconscious you, communicating with the outer world. . . ."

The Strange Life of Charles Waterton. By RICHARD ALDINGTON. 231 pages. Cloth. Duell, Sloan and Pearce. New York. 1949. Price $3.00.

Charles Waterton has been labeled the "Last Great Eccentric," combining many of the qualities of a Catholic Charles Darwin with a flair for getting into situations reminiscent of Baron Munchausen. After a youth spent in a series of escapades, often involving climbing after birds' nests at the most unpropitious times, Waterton found himself a plantation manager in British Guiana. This was soon too dull and he took a series of trips into the interior, on all acquiring natural history specimens, the first being distinguished by his collection and testing of curare. On returning to England he snubbed, for religious reasons, a friendly government, and established his home, Walton Hall, as the first bird and animal sanctuary.

Charles Waterton is never made to seem a real person in this book. Mr. Aldington in a half-affectionate, half-sneering style has made apparent many of his motivations and characteristics, but he has not succeeded in making him a human, sympathetic being.

The Mark of Oppression. By ABRAM KARDINER, M. D., and LIONEL OVESEY, M. D. xvii and 396 pages. Cloth. Norton. New York. 1951. Price $5.00.

A basic Negro personality in the United States, caused, not by in-born, but by environmental, factors, is here postulated. Anxiety and the stress caused by keeping aggressive feelings repressed are universal. A society dominated in large part by women is common; this was caused, first, by the mother-child relationship being the only stable one during slavery, and more recently by the economic insecurity of Negro men. Psychoanalytic interviews were conducted on 25 cases and the results were correlated with Rorschach tests done under well-controlled conditions. As the authors point out, this number of cases is insignificant when studying population trends, etc., but has far more meaning in psychodynamics. To have increased the number of cases would have added greatly to the length of time before publication, and this excellent "pilot study" will pave the way for future investigations.

Somatic Development of Adolescent Boys. By HERBERT R. STOLZ, M. D., and LOIS M. STOLZ, Ph.D. xxxiv and 557 pages. Cloth. Macmillan. New York. 1951. Price $9.00.

The emphasis in this book is upon the purely physical aspects of adolescence, with a comprehensive examination of periods of growth and as to specific type of growth, such as genital and bone structure. There is, however, an extremely interesting case history, "The Case of Ben," which is used to illustrate the emotional upsets that may occur when developmental age precedes the chronological age.

Rural Social Systems. By CHARLES P. LOOMIS and J. ALLAN BEEGLE. 873 pages. Cloth. Prentice-Hall. New York. 1950. Price $6.75.

The authors' aim in writing this text was to convert rural sociology findings into a body of scientific sociological knowledge, an "attempt to carry this trend a long step forward by presenting a solid core of conceptual interpretation of those types of social phenomena which have either easily identifiable social structure or are oriented by values."

The authors have selected several clearly definable elements of rural sociology, such as social level, educational background, family status, and occupational activities and treated these topics in such an interesting and thorough manner that a clear understanding of the structure and functioning of rural society as a whole is vividly depicted.

An outstanding feature is the wealth of graphic material and sociometric charts which clarify and simplify what might have been complicated data. There is no doubt that this book will become an outstanding text for sociologists who are interested in a scientific approach.

Statement on Race. By ASHLEY MONTAGU. 172 pages. Cloth. Schuman. New York. 1951. Price $2.00.

This is an amplification and a simple explanation of the meaning and content of the famous UNESCO "statement by experts on race problems." The concept of human race is generally misunderstood and generally misused. Its misunderstanding has provided in recent years one of the most fertile grounds in history for the cultivation of paranoid ideology. The careful and greatly condensed statement on race which was issued by UNESCO last summer is here taken up paragraph by paragraph and explained in plain language.

Professor Montagu's book should be understandable at the high school level. Its wide circulation would be an important service to mental hygiene.

The Idea of Psychosomatic Medicine. By CURT S. WACHTEL, M. D. xiv and 239 pages. Cloth. Froben Press. New York. 1951. Price $5.00.

Far more a philosophical than a medical study, Dr. Wachtel's work advocates the recognition of the soul as the major criterion in the evaluation of the individual; and he states: "The soul in psychosomatic and integral medicine of the person is at least as real as the molecule and atom in physics." An explanation of Roman Catholic morals in regard to medicine is given. No conflict is held to be inherent between psychoanalysis and religion, and "Psychoanalysis correctly practiced may well be in agreement with the strictest moral principles."

Carbon Dioxide Therapy. A Neurophysiological Treatment of Nervous Disorders. By L. J. MEDUNA, M. D. 219 pages. Cloth. Thomas. Springfield, Ill. 1950. Price $5.00.

Perhaps most older psychiatrists have, at one time or another, experimented, if only briefly, with treatment by carbon dioxide. They have seen severe catatonic schizophrenics "snap out of" their lethargy only to lapse into their states of ecstacy as the stimulation of carbon dioxide wore off. This has suggested to many that catatonia is a physiological abnormality and that it can be cured by physiological and biochemical means. This has also been Meduna's contention, but he has believed that schizophrenic disturbances are too severe to be materially changed by CO_2 inhalation. Therefore, he decided to experiment with psychoneurotic conditions. He states in his preface that his carbon dioxide method will enable the family doctor to treat psychiatric disorders, since symbolic explanations and psychotherapy are unnecessary. He suggests that psychiatrists and psychoanalysts in particular have wasted a lot of time in interpretive methods.

Meduna reviews the literature on the effects of carbon dioxide on the nervous system, and that pertaining to experimental results. Then he describes his own method, following with his report on 100 cases of psychoneuroses and psychosomatic disorders other than obsessive-compulsive neuroses. Meduna claims 68 per cent of improvements. Finally, he defines and describes what he calls his "neurophysiological theory." His theory is a complicated one, and this final chapter must be read in its entirety to understand it. However, very briefly, one might state that his belief is that carbon dioxide administration cures psychoneurotic conditions by producing a homeostasis of the neurological anatomy.

ERRATUM

Science and Common Sense. By JAMES B. CONANT. 371 pages. Cloth. Yale University Press. New Haven, Conn. 1951. Price $4.00.

Through a mechanical error which was not detected until after publication, Dr. Conant's book, *Science and Common Sense,* was reviewed in the April 1951 PSYCHIATRIC QUARTERLY with the authorship attributed in the heading to James T. Farrell. The review appeared on page 347, and subscribers are requested to correct their copies. The review itself, however, stated plainly that the book was written by President Conant of Harvard University.

CONTRIBUTORS TO THIS ISSUE

VICTOR W. EISENSTEIN, M. D. Dr. Eisenstein is chief of the psychiatric clinic and associate attending neuropsychiatrist at Lenox Hill Hospital, New York City.

He was graduated from George Washington University Medical School in 1929, was resident in neurology at the Goldwater Memorial Hospital, New York City; resident in psychiatry at the New York State Psychiatric Institute, and received further training at the New York Psychoanalytic Institute. He is a diplomate of the American Board of Psychiatry and Neurology; a fellow of the American Psychiatric Association and a member of various professional societies.

His publications have appeared in THE PSYCHIATRIC QUARTERLY, the *Psychoanalytic Quarterly*, the *Psychoanalytic Review*, the *Journal of the American Medical Association*, the *Archives of Neurology and Psychiatry*, and the 1950 *Year Book of Psychoanalysis*.

PAUL H. HOCH, M. D. Dr. Hoch is principal research scientist (psychiatry) of the department of research psychiatry at the New York State Psychiatric Institute. He is research and teaching collaborator in the psychoanalytic clinic for training and research at Columbia University and is assistant professor of psychiatry in the College of Physicians and Surgeons at Columbia University. A graduate of the University of Göttingen in 1926, he was assistant at the university clinic in neurology and psychiatry in Göttingen and assistant physician and assistant professor of neurology and psychiatry on the medical faculty of the University of Göttingen. He served on the staff of Manhattan (New York) State Hospital in charge of shock treatment and was consultant in psychiatry to the United States Public Health Service early in World War II before joining the staff of the New York State Psychiatric Institute. Dr. Hoch has done extensive research and teaching and is the author of numerous publications. He is a former president of the American Psychopathological Association and is now chairman of the committee on therapy of the American Psychiatric Association. He is co-author of the volume, *Shock Treatment and Other Somatic Procedures in Psychiatry*, was editor of *Epilepsy*, and of *Failures in Psychiatric Treatment* and was co-editor of *Psychosexual Development in Health and Disease* and of *Anxiety*.

CARNEY LANDIS, Ph.D. Dr. Landis received his Ph.D. degree at the University of Minnesota in 1924. Following study in England and France, he was appointed research associate in psychology (principal research psychologist) at the New York State Psychiatric Institute in 1930

and has held that position since that time. He is professor of psychology at Columbia University and has published many articles and books on abnormal psychology and psychopathology.

EDMUND BERGLER, M. D. Dr. Bergler is a New York psychoanalyst who frequently contributes to this QUARTERLY. A graduate of the University of Vienna Medical School, he was formerly assistant director of the Psychoanalytic Clinic in Vienna, and was widely known in Europe before coming to the United States. He is the author of more than 100 published scientific articles; and has written a number of books, published both here and abroad, addressed to the general reader as well as to the medical profession.

ROBERT W. GANS, M. D. Dr. Gans received his M. D. degree in 1937 from the Bellevue College of Medicine. Following internship and a period of general practice, he joined the staff of Rockland (New York) State Hospital in 1941, where he remained until 1949, except for army service during World War II. He is now a clinical assistant, visiting in psychiatry, at Bellevue Hospital, and is in private practice in psychiatry in New York City. He is a diplomate in psychiatry of the American Board of Psychiatry and Neurology.

LEOPOLD P. DEUTSCH, M. D. Dr. Deutsch, a graduate in medicine of the University of Vienna in 1928, interned in Vienna and took postgraduate training in neurology and psychiatry in that city. He was later resident and assistant director of the Hospital for Nervous Diseases at Rosenhuegen. He was on the staff of Rockland (New York) State Hospital from 1941 to 1948, following which he has been in private practice in New York City. He is a diplomate in psychiatry of the American Board of Psychiatry and Neurology and has held a number of visiting and consulting positions.

M. S. LIPTON, Ph.D. Dr. Lipton is clinical psychologist at Brooklyn (New York) State Hospital and is senior psychologist at Brooklyn neuropsychiatric clinic. He is an instructor in psychology at the College of the City of New York. He received his Ph.D. from Columbia in 1951.

S. L. TAMARIN, M. D. Dr. Tamarin is a senior psychiatrist on the staff of Kings County (New York) Hospital. At the time the paper in this issue of THE PSYCHIATRIC QUARTERLY, of which he is co-author, was written, he was a supervising psychiatrist at Brooklyn (New York) State Hospital. He is a fellow of the American Psychiatric Association and is a diplomate of the American Board of Psychiatry and Neurology.

P. LOTESTA, M. D. Dr. Lotesta is a psychiatrist in private practice in Brooklyn, N. Y., and a neuropsychiatrist at the Brooklyn V. A. Regional Office. He was formerly senior psychiatrist at Brooklyn (New York) State Hospital. He is a diplomate in psychiatry of the American Board of Psychiatry and Neurology.

REUBEN M. CARES, M. D. Dr. Cares is director of clinical laboratories at Kings Park (New York) State Hospital. He received his medical degree in 1928 from Long Island College of Medicine, after graduation in 1925 from the College of the City of New York. He trained in pathology at Mt. Sinai Hospital, New York City, after which he was assistant pathologist at Israel Zion Hospital. He served four years as chief of laboratory service and pathologist in army hospitals and in an overseas central laboratory during World War II. His interest and publications were until then in general pathology.

Dr. Cares entered the New York State Department of Mental Hygiene in 1946, taking postgraduate studies at the neuropathology laboratories of the Psychiatric Institute. In 1949, he was appointed assistant in neuropathology at Mt. Sinai Hospital, New York City. He has taught histopathology at the Long Island College of Medicine. He is a diplomate of the American Board of Pathology, a member of the College of American Pathologists, and of a number of professional societies. He is continuing research on brain tumors at Kings Park State Hospital, and at Mt. Sinai with the Mt. Sinai neuropathologist, Dr. J. H. Globus.

F. A. FREYHAN, M. D. Dr. Freyhan, born in Berlin in 1912 and a graduate in medicine of the University of Berlin in 1937, is clinical director of Delaware State Hospital and an associate in the department of psychiatry at the University of Pennsylvania Medical School. He is a fellow of the American Psychiatric Association, a member of other professional associations, and a diplomate in psychiatry of the American Board of Psychiatry and Neurology.

ROBERT SEIDENBERG, M. D. Dr. Seidenberg is a graduate of the College of Liberal Arts of Syracuse University and of the Syracuse University College of Medicine. He served a rotating internship at the Syracuse Medical Center, after which he was in the army from 1944 to 1946. He attended the school of military neuropsychiatry at Mason General Hospital, Brentwood, N. Y., and later was chief of the neuropsychiatric section, Army Station Hospital, Florence, Ariz. He served as resident psychiatrist at Syracuse Psychopathic Hospital, working on psychosomatic research in the out-patient clinic.

HERBERT C. MODLIN, M. D. Dr. Modlin is senior associate psychiatrist at the Menninger Foundation, Topeka, Kan.; lecturer in psychiatry at the University of Kansas Medical School; senior psychiatric consultant at Topeka State Hospital; a member of the dean's subcommittee for neuropsychiatry of Winter V. A. Hospital, and associate editor of the *Bulletin of the Menninger Clinic*. Born in Chicago in 1913, he grew up in Omaha, Neb., and received his undergraduate and medical education from the University of Nebraska. Following internship, he served residencies or fellowship appointments in Nebraska, Massachusetts, Pennsylvania and Canada. After some three years in the army, he joined the staff of Winter V. A. Hospital, Topeka, Kan., as section chief and later as chief of the neuropsychiatric service. He moved to the Menninger Clinic in 1949. Dr. Modlin is a fellow of the American Psychiatric Association and a member of a number of other professional societies. He is a diplomate of the American Board of Psychiatry and Neurology.

ADOLF ZECKEL, M. D. Dr. Zeckel is a psychoanalyst in private practice in New York City and is an associate in psychiatry at Columbia University where he is engaged in a research project on psychosomatic factors in nerve-deafness. Born in Groningen, The Netherlands, in 1904, Dr. Zeckel received his medical degree at the University of Groningen Medical School in 1928. He followed with four years of training in neurology and psychiatry and then engaged in private practice in Rotterdam where he was particularly interested in problems of deafness, and was director of the psychological laboratory of the Institute for the Deaf. He started his psychoanalytic training in Holland and completed it in New York where he was graduated from the Psychoanalytic Institute.

JULIUS KATZ, M. D. Dr. Katz, a graduate of Long Island College Hospital in 1928, is director of the bureau of tuberculosis control in state institutions of the New York State Department of Health, Division of Tuberculosis Control. He has taken part for some years in tuberculosis work in the New York State mental hospitals and he has been a previous contributor to this QUARTERLY as well as other scientific journals.

ROBERT E. PLUNKETT, M. D. Dr. Plunkett is assistant commissioner for tuberculosis control of the State of New York Department of Health. He is a diplomate of the American Board of Preventive Medicine and Public Health and is a member of the board of directors of the National Tuberculosis Association. He is the author of numerous scientific articles published in various journals on clinical, epidemiological and public health aspects of tuberculosis.

FREDERICK MacCURDY, M. D. Dr. MacCurdy is medical consultant to the New York State Citizens Committee of 100 for Children and Youth. He was formerly commissioner of mental hygiene of the State of New York. Dr. MacCurdy is a graduate of the University of Washington and of the College of Physicians and Surgeons, Columbia University. In private practice in New York City prior to World War I, he served with the United States Army Medical Corps overseas. On his return to New York, he became active in planning, and later in administering, the new Columbia-Presbyterian Medical Center. He was professor of hospital administration at Columbia and director of the Vanderbilt Clinic when he was named commissioner of mental hygiene in 1943, a position he resigned in April 1950 to take his present post.

NEWS AND COMMENT

CLEGHORN TO GIVE THIRD HUTCHINGS MEMORIAL LECTURE

Robert A. Cleghorn, M. D., associate professor of psychiatry at McGill University, will deliver the third memorial lecture in honor of the late Dr. Richard H. Hutchings at Syracuse University on October 1, 1951. His title will be "The Interaction of Physiological and Psychological Processes in Adaptation." Miles Jones, Utica (N. Y.) attorney, will also speak, on "Doctor Hutchings." The lecture will be given at 8:30 p. m. in the auditorium of the College of Medicine. Members of the medical profession and students of medicine are invited.

Co-sponsors of the memorial lecture are the Dr. Richard H. Hutchings Memorial Trust Fund Committee, the Onondaga County Medical Society, the Syracuse Academy of Medicine, and the College of Medicine, Syracuse University.

Dr. Hutchings, former editor of this QUARTERLY, former superintendent of Utica and St. Lawrence (N. Y.) State hospitals, and author and teacher, died in October 1947. Dr. Harry A. Steckel, former director of Syracuse Psychopathic Hospital, heads the memorial committee which was set up by friends and colleagues of Dr. Hutchings to sponsor the lecture series. New York State commissioner of mental hygiene, Newton Bigelow, M. D., present editor of this QUARTERLY, is secretary of the committee. Previous lecturers were Dr. Winfred Overholzer, superintendent of St. Elizabeths Hospital, Washington, D. C., who delivered the 1949 lecture; and Dr. Harry C. Solomon, medical director of Boston Psychopathic Hospital, who gave the 1950 lecture.

Dr. Cleghorn notes that his lecture will "review some of the older and more recent points of view which imply the importance of considering the human being from purely physiological and psychological points of view, and to endeavor to integrate some of the newer knowledge regarding the response of the individual to stress. This will involve particularly a consideration of the recently acquired knowledge of the effect of hormones on mental states."

SAMUEL W. HAMILTON, M. D., DIES AT 72

Samuel W. Hamilton, M. D., past president (1946-1947) of the American Psychiatric Association and an internationally-known leader for many years in the psychiatric and mental health fields, died on July 27, 1951, on a visit to the superintendent's office of the Rutland (Vt.) State Women's Reformatory. Dr. Hamilton, who retired from hospital and public health work last year as superintendent of the Essex County Over-

brook Hospital, Cedar Grove, N. J., was visiting the Rutland institution to confer on a forthcoming government survey. He was 72 years old and had been engaged in the active practice of psychiatry for more than 45 years.

Born in Brandon, Vt., Dr. Hamilton attended the University of Vermont and was graduated from the College of Physicians and Surgeons, Columbia University, in 1903. He was assistant physician at Manhattan (N. Y.) State Hospital and senior assistant physician at Utica (N. Y.) State Hospital from 1905 to 1916, during which period he was volunteer assistant for a time at the mental and nervous clinic, University of Breslau, Germany. He later headed the police psychopathic laboratory, New York City, and served in the army during World War I. He became medical director of the Philadelphia Hospital for Mental Diseases in 1920. He was assistant medical director of Bloomingdale Hospital (New York Hospital—Westchester Division) from 1923 to 1936. He served for many years as director of the division on hospital service of the National Committee for Mental Hygiene, and was director of that organization's mental hospital survey committee from 1936 to 1939. He became mental hospital advisor to the United States Public Health Service in 1936 and assumed the superintendency of the Essex County Hospital in 1947.

Dr. Hamilton returned to his home state on his retirement and made his home at Burlington, Vt. He was widely known as an author, lecturer, administrator and adviser on psychiatric and mental hygiene subjects and was the writer of numerous publications. Among his various posts and memberships was membership on the Dr. Richard H. Hutchings Memorial Trust Fund Committee.

HYPNOSIS SOCIETY TO MEET

The Society for Clinical and Experimental Hypnosis announces that its second annual meeting will be conducted on September 29, 1951 at the New York Academy of Sciences, New York City. The announcement, made on behalf of the society by William T. Heron, Ph.D., notes that all who are interested in the scientific aspects of hypnosis will be welcome. The society is to publish its first *Annual Review of Hypnosis* in September.

M. MORTIMER SHERMAN, M. D., DIES AT 62

Dr. M. Mortimer Sherman, formerly chief alienist at Kings County (N. Y.) Hospital and widely known for expert testimony in criminal cases, died at his home in Brooklyn on June 21, 1951 at the age of 62. Dr. Sherman, a graduate of Long Island College Hospital, was chief alienist at Kings County Hospital from 1917 to 1928. He was the author of numerous scientific and popular articles dealing with psychiatric aspects of criminology.

HEALTH CONGRESS TOPICS ANNOUNCED

Major discussion topics for the plenary sessions of the Fourth International Congress on Mental Health in Mexico City, December 11-19, 1951, have been announced as: mental health in children; occupational mental health—rural and industrial; mental health problems of transplantation and migration; and community efforts in mental hygiene. There will be a series of technical meetings with speakers and discussants from the various countries and professions represented at the congress.

—o—

INTERNATIONAL COMMITTEE FORMED

Formation of the International Committee of Group Psychotherapy under the auspices of the Moreno Institute, has been announced by the Institute. It includes an advisory board and an executive action committee with French, English, American and Austrian sections. J. L. Moreno, M. D., is an American member of the advisory board and of the American section, and the main office for the committee is at the Moreno Institute, Beacon, N. Y. The committee announces its objectives as defining the standards of group psychotherapy; preparing for the first international congress of group psychotherapy; and sponsoring the *International Archives of Group Psychotherapy*.

—o—

DR. MASSERMAN IS WORLD HEALTH CONSULTANT

Jules H. Masserman, M. D., associate professor of nervous and mental diseases at Northwestern University and scientific director of the National Foundation for Psychiatric Research, has been appointed consultant to the Secretariat of the United Nations and designated to present a series of lectures at universities throughout Europe in October and November of this year.

—o—

GROUP THERAPY SURVEY UNDER WAY

The QUARTERLY has been requested by Wilfred C. Hulse, M. D., on behalf of the commission on group psychotherapy in private practice of the American Group Psychotherapy Association, to announce that a survey is being undertaken on the use of group psychotherapy in private practice. Dr. Hulse notes that one session of the 1952 annual meeting of the association is expected to be devoted to this subject. All users of group therapy in private practice have been invited to participate, and questionnaires may be obtained from Dr. Hulse at 110 West 96th Street, New York 25, N. Y.

THE AMERICAN JOURNAL OF MENTAL DEFICIENCY

RICHARD H. HUNGERFORD, *Editor*

Volume 55 OCTOBER 1950 No. 2

TABLE OF CONTENTS

Price $7.00 per volume $2.00 a copy

Editorial Office—224 East 28 Street, New York 16, N. Y.

Richard H. Hungerford, M. A., *Editor*

Business Office—P. O. Box 96, Willimantic, Conn.

Neil A. Dayton, M. D., *Business Manager*

QUARTE

CONTENTS